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# STRENGTHENING FAMILY PLANNING POLICIES AND PROGRAMS IN DEVELOPING COUNTRIES: AN ADVOCACY TOOLKIT



USAID

**DECEMBER 2005**

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**For more information, please contact:**

POLICY Project  
c/o Futures Group  
One Thomas Circle, NW, Suite 200  
Washington, DC 20005  
Tel: (202) 775-9680  
Fax: (202) 775-9694  
Email: [policyinfo@futuresgroup.com](mailto:policyinfo@futuresgroup.com)  
Website: [www.policyproject.com](http://www.policyproject.com)  
[www.futuresgroup.com](http://www.futuresgroup.com)

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The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.



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# ABBREVIATIONS

AED	Academy for Educational Development	MTCT	Mother-to-child transmission of HIV/AIDS
AIDS	Acquired immune deficiency syndrome	MVA	Manual vacuum aspiration
AIM	AIDS Impact Model	NGO	Nongovernmental organization
ARV	Antiretroviral	PAC	Postabortion care
CBD	Community-based distribution	PLHA	Person living with HIV or AIDS
CEDPA	Centre for Development and Population Activities	PMTCT	Prevention of mother-to-child transmission of HIV/AIDS
CPR	Contraceptive prevalence rate	RHAP	USAID's Regional HIV/AIDS Program
DHS	Demographic and Health Survey	RTI	Reproductive tract infection
GBV	Gender-based violence	SPARHCS	Strategic Pathways to Reproductive Health Commodity Security
GDP	Gross domestic product	STI	Sexually transmitted infection
HIPC	Highly indebted poor country	TOT	Training-of-trainers
HIV	Human immunodeficiency virus	VCT	Voluntary counseling and testing
ICPD	International Conference on Population and Development	UN	United Nations
IEC	Information, education, and communication	UNAIDS	The Joint United Nations Programme on HIV/AIDS
IPPF/WHR	International Planned Parenthood Federation/ Western Hemisphere Region	UNFPA	United Nations Population Fund
IUD	Intrauterine device	UNGASS	United Nations General Assembly Special Session
JSI	John Snow, Inc.	UNICEF	United Nations Children's Fund
LAM	Lactational amenorrhea method	USAID	United States Agency for International Development
MDG	Millennium Development Goal	WHO	World Health Organization
MNPI	Maternal and Neonatal Program Effort Index		
MOH	Ministry of Health		





# INTRODUCTION

Family planning remains one of the most cost-effective public health measures available in developing countries. Use of family planning is associated with lower rates of maternal and infant mortality and can influence economic growth. It is an essential component in the prevention of mother-to-child transmission (PMTCT) of HIV/AIDS and in adolescent reproductive healthcare programs, and it can play a role in improving gender equity. Expanding access to and improving the quality of family planning programs around the world is central to improving and maintaining the health of individuals and societies and helping them reach their full potential.

The POLICY Project is committed to keeping family planning issues at the forefront of local, national, regional, and international health and development discussions, initiatives, and programs. Awareness about declining resources for family planning initiatives, programs, and services has increased in the last few years with new initiatives for “repositioning family planning” and “contraceptive security” observed in many countries and regions. This tool represents an attempt to give step-by-step guidance to help developing country advocates at the community and national levels to move the repositioning and contraceptive security agendas forward and keep the focus on family planning within their broader development goals.

The purpose of this toolkit is to assist advocates in the family planning/reproductive health field in their efforts to promote policy dialogue on the health, social, and economic benefits of increasing access to family planning services. By tailoring the messages included in the toolkit, advocates can present culturally relevant arguments to promote family planning and birth spacing in their particular settings.

The toolkit is divided into seven chapters covering the following topics:

- Family planning and maternal and infant mortality and morbidity
- Family planning and macro-level socioeconomic impacts
- Family planning and prevention of mother-to-child transmission of HIV
- Family planning and gender equity
- Adolescent reproductive health
- Country-level advocacy strategies
- Models, frameworks, and tools

Chapters are divided into theme-based sections, which provide a short background on the issue and a synopsis of key points. Each section also includes examples of successful advocacy strategies and one or two illustrations of country experiences that led to policy change.

This toolkit is designed to be user-friendly. The user can refer to a single section on a particular topic or cross-reference multiple sections, using examples from the strategies, illustrations, tools, and frameworks provided to help the user develop customized advocacy messages and activities. For example, it may be more culturally acceptable to approach family planning in certain countries or regions using a birth-spacing approach. In countries where HIV is prevalent, using the family planning/PMTCT approach may be more appropriate. Where poverty alleviation and the Millennium Development Goals (MDG) are a main focus, linking family planning with macro-level impacts may be most influential.



## CHAPTER 1

# FAMILY PLANNING AND BIRTH-SPACING IMPACTS ON MATERNAL AND INFANT MORTALITY AND MORBIDITY



J. OWEN-RAE/USAID

Having too many pregnancies or pregnancies too closely spaced can negatively impact the health of the mother and her infant. Women and couples with access to family planning methods can more easily space pregnancies and reach their desired family size, which reduce the risk of maternal and neonatal morbidity and mortality. This chapter explains why family planning is necessary to reduce unmet need, achieve optimal birth spacing, reduce maternal mortality and morbidity, and improve child health and survival. It also includes a discussion of the importance of family planning in the postabortion period as well as a section on how to promote contraceptive security.

## SECTION ONE

### UNMET NEED FOR FAMILY PLANNING

#### ISSUE

In 2000, more than 105 million married women in developing countries had an unmet need for family planning—a figure that equates to approximately 17 percent of married women in the developing world. These women would like to delay, space, or limit their fertility in the next two years but are currently not using any method of contraception. Several factors prevent women from gaining access to family planning services, most notably, prohibitive distances to family planning services, lack of transportation, and limited ability to travel to services. In addition, cultural factors contribute to unmet need. For example, some Muslim women may not travel to health facilities or receive care from a healthcare provider without a male escort. Other factors that contribute to women's unmet need for family planning include health provider bias toward one contraceptive method over another, staffing shortages, lack of availability of preferred methods, product stockouts, prohibitive costs of products and services, and lack of client and provider awareness of services. Legislative and policy barriers and religious, sociocultural, and economic norms also adversely influence women's ability to use reproductive health and family planning services effectively.

Unmet need for family planning can lead to high maternal and infant mortality rates. Abortion-related deaths and disabilities are indications of unintended pregnancies and of women's limited access to comprehensive reproductive healthcare and information that might have prevented those abortions. In addition, closely spaced pregnancies and births, early childbearing, and childbearing at the end of the reproductive years all contribute to increased maternal and infant mortality rates.

Desired fertility<sup>1</sup> rates continue to be considerably lower than actual fertility. Demographic and Health Surveys (DHS) consistently show that many women and men would choose to space their next pregnancy by at least two to three years but are not doing so. Recent research by Ross and Winfrey (2002) across 27 developing countries indicates that among women giving birth within the last year two-thirds have an unmet need for family planning. These women are therefore at risk of a closely spaced birth and are likely to have more births than they desire.

Beyond the health and survival implications of high levels of closely spaced and unintended births, high fertility rates accelerate population growth, undermining development efforts across all sectors. Unintended pregnancies and births have a potentially devastating impact on both the individual and society. The pattern of low literacy, high rates of school dropouts, low income-earning potential, and low participation in civil society is all too common among women and girls in countries with high unmet need for family planning. This pattern, combined with high levels of unplanned fertility, makes it difficult for women to become productive members of society, thereby limiting their contribution to economic development and self-development and consigning young girls and their children to a cycle of poverty and ill health. Meeting the family planning and reproductive health needs of couples in developing countries would help households achieve their expressed, desired fertility. It would also go a long way toward meeting critical development goals by improving the lives of women, girls, their children, and families and aligning population growth with the pace of economic development.

1. DHS determines the “wanted fertility rate” by excluding “unwanted” births from the calculation of the conventional total fertility rate. A birth is considered wanted if the number of living children at the time of conception was less than the current ideal number of children reported by the respondent. For example, the Benin 2001 DHS reports that the total wanted fertility rate was 4.6 while the actual fertility rate was 5.6.

## KEY POINTS

**Individuals actively seeking a safe and reliable method of contraception and birth spacing face numerous healthcare quality obstacles.** With respect to healthcare providers, bias toward certain family planning methods and the lack of up-to-date information and training on the use of various methods prevent healthcare professionals from providing high-quality family planning services. For example, a provider might supply only one method type to certain women based on age, health status, or number of children and thus ignore other suitable methods, particularly in the case of adolescents and HIV-positive women<sup>2</sup> seeking family planning. Providers often withhold family planning information from these two groups because they either think that adolescents and HIV-positive women are not engaging in sexual activity or do not approve of them doing so. Providers may also refuse to perform invasive procedures such as intrauterine device (IUD) insertion and sterilization for HIV-positive women for fear of infection. In the face of such discrimination, many women are unable to select from the full range of options or may simply not seek care. For HIV-positive women, failure to seek care can mean the loss of important opportunities for health providers to inform women about pregnancy, labor, and delivery risks; the prevention of mother-to-child transmission; and family planning options within the context of their HIV status.

**In many countries, social and cultural norms prevent women from accessing reproductive healthcare, severely limiting their reproductive choices.** Traditional norms surrounding the behavior of women, including gender inequality, limited socioeconomic standing, low literacy rates, early marriage during adolescence, and high fertility, limit women's ability to act in their own interest and compromise access to reproductive healthcare and family planning services. Longstanding gender norms greatly influence healthcare policy and investments and, ultimately, access to information and services. In many cultures, men control decisions regarding sexual relations, contraception, and HIV prevention. However, the reproductive health needs of men may not necessarily correspond with the needs of women.

**Antiquated or lack of gender-sensitive reproductive health policies adversely affects access to information and services for women.** Policy actions such as legislation, enforcement provisions, institutional arrangements, and dedicated resources can strengthen women's rights, limit traditional harmful practices, improve women's opportunities to stay in school and participate in the workforce, and ultimately improve access to high-quality reproductive healthcare and family planning services. Other policy actions include the development and enforcement of gender-positive policies governing minimum age at marriage, spousal rights, legal age of consent, marital property, physical integrity, inheritance, antidiscrimination, and female genital cutting.

**Many of the barriers limiting access to family planning information and services are basic and well documented.** Lack of information, transportation, or money can substantially limit access to family planning services. Many women and others influential in fertility decisionmaking within the household are often unaware of or lack complete information about available services and contraceptive options. Travel to health facilities may be difficult, time-consuming, and expensive. For many women, the time needed to travel to a family planning clinic means sacrificing income. In the end, even if a clinic is located relatively near a woman's house, the woman will not take advantage of the services if she does not have control over household resources. In many developing countries, healthcare infrastructure and the contraceptive commodity distribution systems are weak and unable to provide a reliable supply of products or method choice.<sup>3</sup>

**Unmet need for family planning has largely gone unnoticed in most national development goals and strategies and has faded in importance.** The recent shift in government and donor resources and attention away from family planning and reproductive health to HIV/AIDS has compounded the failure of most national development goals to focus on family planning and reproductive health issues and impedes the integration of family planning and HIV. Yet, HIV/AIDS and family planning are intrinsically linked because of the mode of HIV transmission. Consistent and correct use of male

2. For more information on this topic, see Chapter 3, Section One.

3. For more information on this topic, see Section Two of this chapter.



and female condoms reduce the risks of both unintended pregnancies and sexually transmitted infections (STIs), including HIV. Classic family planning in the form of behaviors such as abstinence and delayed sexual debut can help to prevent HIV as well. In addition, family planning counseling and supplies are important components of voluntary counseling and testing (VCT) and programs aimed at prevention of mother-to-child transmission of HIV, helping all women make family planning decisions within the context of HIV/AIDS.

## STRATEGIES

Strengthening the healthcare infrastructure and fostering an enabling environment for family planning lie at the heart of a variety of important strategies to address unmet need. Strategies should aim at:

- Advocating to nongovernmental organizations (NGOs) and government agencies to expand and diversify public and private sector sources of family planning information and services in order to increase access to family planning across socioeconomic groups and locations and reduce unintended pregnancies and thus abortions.
- Encouraging strong political will and open support of comprehensive family planning programs.
- Fostering awareness that unintended pregnancies and births can contribute to high rates of population growth, potentially outpacing a country's ability to meet the needs of its citizens and undermining national development goals.
- Promoting gender-sensitive policies and programs, especially within the health and education sectors, to help policymakers recognize and remove obstacles to the accessibility and availability of reproductive health and family planning services.
- Advocating for formal contraceptive security plans to ensure uninterrupted access to a variety of contraceptive methods.
- Integrating family planning and HIV/AIDS programming, such as the addition of family planning information to VCT, PMTCT, and antiretroviral (ARV) services, to increase the likelihood that women will obtain the information they need to make informed decisions regarding fertility and disease prevention.
- Creating formal family planning service norms and protocols for care in combination with sensitization training for healthcare providers in order to reduce the stigma and discrimination faced by women seeking family planning, especially youth and HIV-positive women.

## ILLUSTRATIONS

Interventions that mobilize civil society to advocate for the inclusion of marginalized groups in government programs and policies can play an important role in reducing unmet need for family planning. Together, the U.S. Agency for International Development's (USAID) Regional HIV/AIDS Program (RHAP), with offices in Southern Africa, and the POLICY Project provide support to local NGOs and civil society groups in Swaziland to mobilize resources for reproductive health and HIV/AIDS advocacy projects. RHAP advocates for the inclusion and funding of interventions for HIV-positive women in larger reproductive health programs involving persons living with HIV/AIDS (PLHAs). RHAP is working now to include the needs of HIV-positive women in Swaziland's strategic plan in order to increase access to reproductive health services and raise awareness about stigma and discrimination among service providers. The effort is particularly important because of the marginalized legal status of Swazi women. Women are legal minors, unable to own land or enter into contracts without the consent and cooperation of husbands or male family members. The legal status of women often limits women's decisionmaking power, forcing women to access family planning information and services through men. The education and involvement of men and family members such as mothers-in-law will be an integral part of improving access to family planning for HIV-positive women (POLICY Project, 2004).

An efficient and effective logistics system is an essential component of a comprehensive contraceptive security plan. Logistics personnel must be well trained and armed with the appropriate resources, skills, and tools. System management by experienced, trained personnel leads to increased availability of contraceptives and other essential health products at service delivery points. John Snow, Inc., (JSI), through the Family Planning Logistics Management Project, developed and implemented a variety of interventions as part of a strategy to improve logistics in West Africa (Edah, 2000). Interventions included logistics

workshops for national health service staff and NGOs, training-of-trainers (TOT) workshops, development and field testing of a logistics supervision tool, development of job aids for logistics management tasks, provision of on-the-job training, incorporation of a logistics module into university nursing schools, and regional training for management institutions. JSI conducted logistics TOT workshops in Burkina Faso, Benin, and Togo with 40 trainers in each country. The new trainers went on to train 3,500 Ministry of Health (MOH) staff in provinces and districts. Logistics management staff are participating in training to adopt a customer service attitude to improve availability of contraceptives and other essential health products at all service delivery points.

Expanding the circle of those who are authorized or sanctioned to perform certain reproductive health services can greatly increase the accessibility of those essential services. In Jordan, the Minister of Health approved a pilot program to enable midwives to insert IUDs in order to overcome the shortage of female physicians and respond to the growing need for IUDs. Jordanian counterparts trained by the USAID-supported POLICY Project were instrumental in building the capacity of a physician, who advocated to the Ministry of Health for the midwives' involvement in IUD service provision. The MOH's decision to involve midwives in IUD service provision can be considered a breakthrough in Arab countries, where physicians are usually opposed to nonphysician health providers' delivery of healthcare services (POLICY Project, 2005).

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## SECTION TWO

### CONTRACEPTIVE SECURITY

#### ISSUE

In developing countries, the poor often have the distinction of exhibiting both the highest fertility rates and the lowest contraceptive use rates. Ensuring access to free contraceptives for vulnerable groups should be an essential component of a comprehensive contraceptive security plan. In most developing countries, however, those who can afford to pay for services often benefit from free goods provided by the public sector while individuals who cannot afford to pay for services remain without essential reproductive healthcare.

#### KEY POINTS

**The success of social marketing campaigns for contraceptives, combined with the surge in the percentage of the world's population entering reproductive age, has brought the issue of contraceptive security to the attention of governments around the world, particularly in Latin America.**

Contraceptive security exists when every person is able to choose, obtain, and use contraceptives and other essential reproductive health supplies whenever she or he needs them. However, while demand is rising, the previously donor-led and -funded supply of contraceptives is beginning to dwindle. International donors are phasing out contraceptive donations in developing countries and graduating these countries to a state of contraceptive self-reliance. The graduation process can generate formidable challenges for countries as they take on the programming, budgeting, procurement, and distribution functions formerly under donor control.

**“Health for All” has been a major international public health theme since the late 1970s, but it is important to keep in mind that the promise of free contraceptives for all citizens often cannot be realized in poor countries.** Instead of targeting limited public sector subsidies to those most in need, “free for all” public health sector policies create a situation in which those

who can afford to pay for health services shift from the fee-based private sector to the free or reduced-cost public sector, often leaving the poor with little or no access to free public sector services. Competition between the public and private sectors results in (1) a poorly segmented market, (2) lack of equity between the rich and the poor in terms of access to family planning goods and services, and (3) a weakened commercial sector. The rural poor are further disadvantaged by the lack of public sector providers trained to distribute contraceptives. The ideal scenario for securing contraceptive commodities and services for all funnels scarce resources to those most in need while fostering a system that encourages able-to-pay consumers to rely on the private sector's commercial market.

**In the face of declining donor support, governments striving for self-sufficiency need technical assistance to take over previously donor-led contraceptive security programs and initiatives.** Technical assistance should extend to the delivery of training in inventory, negotiation, and procurement processes as well as in distribution logistics and the accurate projection of contraceptive needs. Providing governments with these essential skills can ease the transition from donor reliance to self-sufficiency, reducing the probability of damaging events such as contraceptive stockouts.

**Contraceptives are effective only when they are accessible and available when the consumer needs and wants them.** When commodities of choice are not available to the consumer, the contraceptive prevalence rate (CPR) inevitably remains low. Regular stockouts can disrupt an individual's ability to protect him- or herself from both unplanned pregnancy and sexually transmitted infections, and stockouts may inordinately compromise women whose contraceptive method options are already limited as a consequence of other factors. An unreliable contraceptive supply can discourage individuals from correctly and regularly using contraceptives. Nonetheless,



a stockout at the consumer level may not indicate a stockout at all points in the distribution chain; the government or central district may be hoarding goods and not distributing them effectively. Regardless of the cause of a stockout, a lack of commodities leads to higher levels of unmet need.

**The concept of contraceptive security not only applies to a sustained supply of contraceptives but also to maintaining an adequate mix of methods.** A woman may choose her contraceptive method based on either her ability to negotiate contraceptive use or her partner's HIV status. Cost of the method and how frequently the method must be resupplied also influence a woman's method choice. A reliable and diverse method mix can help ensure contraceptive security for all who wish to use contraceptives.

**Focusing on attracting those with the greatest economic need for public sector health services, including family planning, ensures that products and services reach those most in need.** Such an approach, often referred to as targeting,<sup>4</sup> is defined as “concentrating [public sector] resources, particularly resources for social programs, on the people who need them the most and would otherwise not have access to them” (Newbrander, Collins, and Gilson, 2001). Targeting can increase coverage for the poor, decrease inequalities, and allow programs to respond to the particular unmet need of their audience.

Opponents argue that targeting undermines the ideal of universal access, but successful initiatives have shown that targeting ensures otherwise unattainable equity (Sine, 2003). Some fear that the private sector in many developing countries is not sufficiently developed to respond to new market opportunities, but targeting can in fact stimulate the private sector to function as a source of family planning commodities, providing opportunities for growth as market share increases. Social marketing can generate demand and increase availability for those able to pay for subsidized products.

## STRATEGIES

Improving contraceptive commodity security should aim at the following strategies:

- Targeting public sector family planning services to those most in need by defining groups and determining need, selecting a characteristic or individual targeting approach,<sup>5</sup> and undertaking operational planning and implementation. Additional targeting of information and education campaigns, behavior change communications, upgrading of public facilities, and improved logistics can also improve equity and access.
- Developing commodity security transition plans within the public health sector to ensure long-term sustainable commodity logistics systems in countries graduating from donor assistance.
- Assisting countries to prepare medium- and long-term contraceptive security plans that allow them to gradually achieve a sustainable country program.
- Securing funding sources to ensure a constant supply of a diverse range of contraceptive methods to reduce unmet need for family planning and reduce family planning discontinuation.
- Promoting and allowing for a viable private commercial market for contraceptive commodities to increase access to family planning and eliminate dependence on the public health sector among those able to pay for family planning services and commodities.

## ILLUSTRATIONS

In 1995, the Ministry of Health (MOH) in Peru instituted and widely publicized a policy mandating provision of free contraceptives for all. The policy dramatically changed the structure of Peru's family planning market. Between 1996 and 2000, the MOH market share increased from 59 to 68 percent while the commercial sector market share declined from 26 to 17 percent. The shift to public sector sources was concentrated among high-income groups, with a 32 percent increase among middle-income clients and a 28 percent increase among upper-middle-income clients. Today, 29 percent of MOH clients belong to the two

4. Targeting is used here as an economic concept for equity. It does not refer to the achievement of family planning goals.

5. Characteristic targeting defines eligibility based on the presence or absence of designated criteria that are readily observable, such as ethnicity or marital status. Individual targeting is based on less observable characteristics such as inability to pay.

top income quintiles and should be able to afford to pay commercial sector prices (Sharma and Shepherd, forthcoming).

In 1999, 48 percent of contraceptives supplied through the public sector in Romania went to those in the highest income bracket while only 30 percent went to the poorest group. In 2000, a government-ordered targeting policy called for free contraceptives for students and the poor.<sup>6</sup> Romania took steps to overcome common targeting challenges by expanding the method mix beyond expensive pill cycles and offering fewer and less costly brands, approving self-certification for eligibility, and covering contraceptives under health insurance plans. The country altered operational policies to permit the distribution of public services and products in difficult-to-access areas. In 2001, Romania authorized the distribution of contraceptives by rural family doctors who had undergone training in family planning and, in 2002, authorized an accelerated family planning training curriculum to help rural family doctors further improve access to services (POLICY Project, 2004).

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6. Poor in this context is defined as the unemployed recipients of social protection allowance and those with minimum or no income.

## SECTION THREE OPTIMAL BIRTH SPACING

### ISSUE

Optimal birth spacing describes the interval between births that yields the greatest health, social, and economic benefits for a family. Until recently, international guidance on birth spacing stated that births should be spaced at least two years apart to ensure maximum health benefits for mothers, newborns, and older children. This recommendation contributed to reductions in maternal and infant mortality and morbidity, reductions in low-birthweight infants, and improved nutritional status among children. However, more current research suggests that birth intervals of three to five years further reduce adverse outcomes associated with pregnancy and the neonatal period and improve health benefits. Evidence-based research on three- to five-year birth intervals shows benefits for infants and older siblings, mothers, fathers, and the entire family. Access to family planning information and services is essential to achieving three- to five-year birth intervals.

### KEY POINTS

**Births spaced three to five years apart are associated with the healthiest maternal and child health outcomes.** Children born three to five years after their next oldest sibling are at the lowest risk of death and illness. Appropriate birth spacing may reduce the risk of low-birthweight babies and newborn death. As for older children under age five, three- to five-year birth spacing may decrease the risk of childhood death as well as reduce the likelihood of stunting and being underweight (Rutstein, 2005). When births are spaced at least three years apart, children can receive the full nutritional benefit of breastfeeding for the recommended two years. Children can also benefit from additional time and nurturing from parents when their younger sibling is at least three years younger.

Recent research on birth spacing indicates that women with pregnancy intervals of less than six months or greater

than five years have higher rates of pregnancy-related illnesses and death than women with interpregnancy intervals of three to five years. Short birth intervals are associated with high rates of early rupture of membranes, bleeding in the last trimester, anemia, and puerperal endometritis—conditions that place women at greater risk of hemorrhage, the primary cause of maternal death. Long birth intervals are associated with higher rates of gestational diabetes mellitus, pre-eclampsia, and eclampsia. Yet, appropriate birth intervals allow mothers to recover physically and emotionally from childbirth and devote more time to infant care (Setty-Venugopal and Upadhyay, 2002).

**Families as a whole benefit from births spaced farther apart.** Many parents must prepare financially and emotionally for a growing family. By spacing births three to five years apart, parents can save money for delivery and the other costs associated with a new child, feel more confident about supporting their family, and have more time to spend with each other.

**Access to family planning is central to achieving longer birth intervals.** To space births three to five years apart, couples should use a family planning method for at least two years. The availability of family planning services, information, and a range of methods is essential if women and their partners are to achieve birth spacing. Messages on birth spacing should be incorporated into family planning counseling for women and men who want to delay first births as well as for couples who already have children. Six months after the birth of a child, mothers planning to use or already using the lactational amenorrhea method (LAM) should be counseled on successfully practicing both LAM and an alternative method of family planning.

**Information on birth spacing should be available through several points of contact.** A variety of social and cultural factors influences family size decisions, and

individuals learn about family planning and health services from many social networks. To expand the distribution of information on birth spacing and family planning, several outlets should deliver messages on the benefits of birth spacing. Optimal birth-spacing information can be made available to women and their partners during standard pregnancy-related appointments such as in the course of receiving family planning, prenatal, and postpartum care services. During these appointments, parents are likely to focus on the health of their child and family. Healthcare providers could also discuss birth-spacing options during newborn check-ups, physical examinations, and as part of postabortion care services. A greater effort could be made to reach men and women through community outreach activities such as women's or men's clubs, literacy groups, microcredit networks, public fairs and other venues, and religious activities. When family planning is approached in the context of optimal birth spacing, it often finds a receptive audience (CATALYST Consortium, 2005).

**Decisions on birth intervals are often social and cultural in nature.** Shorter birth intervals are associated with specific characteristics and cultural practices. For example, a healthy child often provides couples with an incentive to space the subsequent birth. However, if a woman experiences pregnancy loss or her child dies or is unhealthy during infancy, a couple may not wait as long as they would otherwise to have another child. Women's age also affects birth spacing. In many developing countries, younger women are more likely than older women to have their next child in less than three years. Women with no education are also more likely to space births fewer than three years apart than women with some education. Women living in rural areas, with lower social status, and with no job are also more likely to have shorter birth intervals.

Other cultural practices associated with short birth intervals include pressuring couples to begin childbearing shortly after marriage and the preference for male children. Longer intervals are more frequent in cultures that practice prolonged and intense breastfeeding and postpartum abstinence.

Gender and intergenerational family relationships can also strongly influence the number and timing of births in a family. Reaching husbands, mothers-in-law, and other family members often involved in a couple's family planning decisionmaking is crucial in promoting

three- to five-year birth intervals. Explaining the health benefits of birth spacing to the entire family could be a noncontroversial introduction to a discussion of family planning, particularly given that birth-spacing initiatives do not promote any particular family planning methods or family size.

## STRATEGIES

Increasing access to high-quality family planning services is the principal strategy for promoting optimal birth spacing. Critical issues related to the strategy include:

- Ensuring the availability of a full range of family planning methods to allow couples to find a method that suits their needs. The availability of a complete mix of methods offers couples the option of returning to a provider for an alternative method if they are dissatisfied with a previous method, thereby encouraging uninterrupted use of family planning.
- Providing access to a variety of sources of family planning to help individuals obtain needed contraceptive supplies. Contraceptive security helps ensure continuation of use.
- Integrating family planning counseling into antenatal, postpartum, and postabortion care to provide women with critical information at a time when they need to know about the benefits of birth spacing.
- Ensuring skilled care at delivery and improving child health programs to help protect the lives of newborns and provide opportunities to inform women about birth spacing.
- Working with communities to facilitate the communication of messages about birth spacing to people where they live and work. Informing religious leaders of the many benefits of birth spacing and encouraging the discussion of the topic at places of worship is just one example of working with nontraditional or non-health community partners. Community-level communication can help health workers better understand how to work within cultural environments to address norms and practices that may be detrimental to optimal birth spacing.
- Working and advocating with family health partners not usually involved in family planning to expand the opportunities to promote the health benefits of

spacing. Such health partners may include pediatricians and nurses who can discuss birth spacing with parents during child health visits.

- Working with political leaders and other policy and public finance leaders to help ensure political capital and funds dedicated to birth-spacing activities.

## ILLUSTRATION

The CATALYST Consortium, a USAID-assisted program that promotes optimal birth spacing, reaches communities, professionals, and political leaders with messages of support for family planning services. The consortium bases its work on existing norms in order to educate individuals on the benefits of family planning without promoting a specific family planning method or family size. Working with leaders from conservative Christian communities in Egypt, the consortium developed messages on optimal birth spacing that reflected the communities' traditional birth-spacing ideas and successfully turned influential opinion leaders into optimal birth-spacing supporters. While working with sheiks and traditional Islamic leaders in Egypt and Pakistan, the CATALYST Consortium referred to passages in the Koran to support optimal birth-spacing messages.

As part of the consortium's efforts to incorporate information on traditional fertility decisionmaking into the development of birth-spacing programs, the consortium held focus group discussions with healthcare providers, women, their husbands, and mothers-in-law in Bolivia, Egypt, India, Pakistan, and Peru. In all countries, healthcare providers, women, and men felt that birth spacing of at least two years was beneficial to the health of the mother and child and advantageous to the family's economic well-being. Cultural beliefs and gender inequity, however, strongly influence birth-spacing decisions, with mothers-in-law in Egypt, India, and Pakistan undermining

attempts at recommended birth spacing. In addition, men make most decisions around sexual relations and timing of pregnancy. Additional barriers hampering optimal birth spacing included inaccurate or incomplete knowledge of the health effects of contraceptives, lack of access to family planning services, religious beliefs prohibiting contraception, and lack of clear guidance to healthcare providers on optimal birth spacing. The focus group findings will help the CATALYST Consortium develop information guides, counseling materials, and healthcare provider training guides in support of optimal birth spacing (CATALYST Consortium, 2004).

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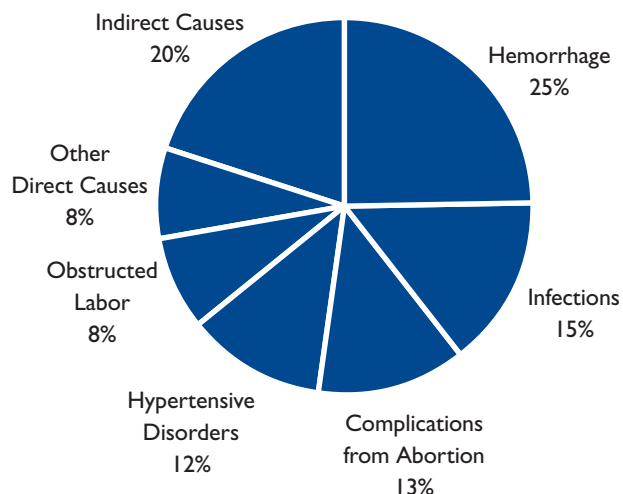
## SECTION FOUR MATERNAL MORTALITY AND MORBIDITY

### ISSUE

Every year, more than 500,000 women worldwide die from pregnancy-related causes, with the vast majority of deaths occurring in developing countries. For every maternal death, approximately 30 more women are left temporarily or permanently disabled (Ashford, 2002). In 2000, the maternal mortality ratio in developing regions reached an average of 440 maternal deaths per 100,000 live births. In sub-Saharan Africa, where the regional maternal mortality ratio was 920 maternal deaths per 100,000 live births, one in 16 women will die of pregnancy-related causes in her lifetime (WHO, UNICEF, and UNFPA, 2004). Unfortunately, the number of maternal deaths has changed little over the last decade despite the growing body of information on effective preventive and curative measures. Most maternal deaths result from hemorrhage, infections, complications from abortion, hypertensive disorders, and obstructed labor (see Figure 1). Maternal morbidity includes any illness or injury due to or exacerbated by pregnancy or childbirth. Most maternal disabilities are caused by direct causes such as severe bleeding, infection, obstructed or prolonged labor, pregnancy-related hypertension, and abortion complications. Indirect causes for maternal morbidity include illnesses aggravated by pregnancy such as anemia, malaria, cardiac disease, hepatitis, tuberculosis, sexually transmitted infections including HIV/AIDS, and diabetes. These disabilities affect a woman's quality of life, fertility, and productivity long after pregnancy and delivery (Ashford, 2002).

Maternal deaths and disabilities have profound effects on a household and community. A mother's death or illness means the loss of the caretaker of children and other family members, which could lead to the declining health of the family and even increased risk of death for

**Figure 1. Causes of Maternal Death<sup>7</sup>**



Source: WHO, 2005.

her children. A family could also face economic hardships when a mother dies or is no longer able to work, which may result in children entering the workforce. Healthy women who are able to meet their child spacing and family size goals may also have more time to dedicate to the development of their family, community, and self.

As described in Section Three of this chapter, mothers whose births are spaced three to five years apart face lower risks of pregnancy-related death and illness and are able to meet the needs of a growing family. Family planning use is essential to birth spacing and reducing exposure to the risks of pregnancy (Setty-Venugopal and Upadhyay, 2002).

Indeed, great improvements in maternal healthcare and prevention must occur to decrease maternal disabilities and deaths and their impacts on families and

7. Totals do not add up to 100 percent due to rounding.

communities. Interventions such as skilled attendance at birth, active management of the third stage of labor, and access to emergency obstetric care are essential components of delivery care. Antenatal, postpartum, and postabortion services are also important in addressing the causes of maternal deaths and disabilities. In addition, micronutrient supplements; malaria prophylaxis; HIV/AIDS counseling, testing, and treatment; information on delivery and postpartum care and postpartum family planning and related health services and referrals; and family planning services are prerequisites to improving the health outcomes of mothers before and after birth and to preventing abortions of unintended pregnancies.

## KEY POINTS

**Among other needed interventions, high-quality, voluntary family planning services, including counseling and access to a range of methods, are central to maternal health and survival.** Use of family planning permits couples to reach their fertility goals while avoiding often dangerous pregnancies such as pregnancy in the early teen years, closely spaced pregnancies, or pregnancies late in a woman's reproductive years. With each pregnancy and birth, women are exposed to the risk of death and disability. Women with many children not only increase their risk exposure, but they may also find themselves in less-than-optimal physical condition for a healthy pregnancy and delivery, especially if their pregnancies were closely spaced. In addition, women over the age of 35 are at greater risk of pregnancy complications and death. Family planning programs can reduce the incidence of abortion and possible unsafe procedures by reducing unintended pregnancies (CATALYST Consortium, 2005).

By allowing couples to plan the timing and number of children, family planning provides women with greater opportunities to participate in activities that could improve the economic or social status of the family.

**Recent research finds that short and long birth intervals place mothers at greatest risk of death and disability** (Conde-Agudelo and Belizan, 2000). Women conceiving 18 to 23 months after a previous birth are at lower risk of maternal death, premature rupture of membranes, third-trimester bleeding, anemia, and puerperal endometritis than women with interpregnancy intervals less than six months. Women

with interpregnancy intervals greater than 59 months were more likely to experience pre-eclampsia and eclampsia. All these complications place women at risk of hemorrhage, the primary cause of maternal death. Use of family planning not only prevents closely spaced pregnancies but also allows a woman's body time to regain strength between pregnancies and permits a woman to prepare financially and psychologically for her growing family.

**High-quality maternal health services can help prevent maternal disability and death while promoting and providing family planning services.** Health professionals' use of health technologies and procedures along with community-based birth preparedness programs can make a mother's death or disability an exceptionally rare event. By educating health professionals and community members about family planning and offering services through maternal health programs, family planning use will become a standard component of maternal health services and a social norm.

## STRATEGIES

Strategies to improve maternal health outcomes through family planning services include the following:

- Educating young and newly married women on the benefits of family planning before their first pregnancy to help them make more informed decisions about the timing and spacing of their children, stressing the advisability of delaying their first pregnancy until at least 18 years old to prevent maternal disability and death.
- Strengthening existing services, including high-quality family planning counseling and the availability of a range of methods, to help women prevent unintended pregnancies and delay, limit, or space births for optimum health. Couples should use a reliable method of family planning for at least two years for optimal birth spacing of three to five years. Use of family planning can reduce unintended pregnancies, related abortions, and health risks.
- Educating family members, in particular husbands and mothers-in-law, and other influential members of society about the dangers of early, late, closely spaced, or too many pregnancies to help them become advocates for healthy pregnancies and family planning.

- Integrating family planning counseling into antenatal, postpartum, and postabortion care to increase the availability of family planning services and provide women with critical information at a time when they are thinking about their health and family. Training midwives and other health professionals in family planning can also expand the reach of these services (Tinker and Ransom, 2002).
- Ensuring skilled care at delivery to save the lives of women and provide opportunities to inform women about birth spacing.
- Educating a pregnant woman's family, in particular husbands and mothers-in-law, and the entire community about the danger signs of complications during pregnancy and delivery not only to help them prepare for obstetric emergencies but also to raise awareness and develop healthy family planning and birth-spacing norms within the community.
- Collaborating with family planning and safe motherhood organizations to advocate to local and national governments to commit to safe motherhood policies, funding, and interventions, thus ensuring family planning resources and standards of quality care.
- Advocating to national political leaders to fulfill the commitments to family planning and safe motherhood the host country has made at international forums.

## ILLUSTRATION

A recent analysis by the Global Health Council found that, between 1995 and 2000, nearly 700,000 women in developing countries died as a result of an unintended pregnancy. These maternal deaths represent more than 20 percent of all maternal deaths during the six-year period. More than 300 million of the 1.2 billion pregnancies in the world over the same six years were unintended. While the annual number of births worldwide has steadied at approximately 131 million, the number of maternal deaths due to unintended pregnancies has risen. The Global Health Council estimates that, between 1995 and 2000, three-quarters of unintended pregnancies ended in abortion, many under unsafe conditions leading to death. The analysis estimates that one in seven maternal deaths is attributable to abortion complications. The analysis also points out that maternal mortality is associated with

lack of access to reproductive healthcare, including family planning. Access to high-quality family planning services allows women to determine the timing and spacing of their pregnancies, therefore reducing the number of unintended pregnancies and associated maternal mortality (Global Health Council, 2002).

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## SECTION FIVE

### CHILD HEALTH AND SURVIVAL

#### ISSUE

Worldwide each year, more than 10 million children under age five die from mostly preventable causes (UNICEF, 2005). The vast majority of these deaths occur in the developing world where poverty, poor and persistent health and environmental conditions, and limited healthcare place children at risk of illness and death. Direct causes such as diarrhea, malaria, respiratory infections, and vaccine-preventable diseases, including measles, account for the largest share of these deaths. Malnutrition, lack of access to safe drinking water, and poor sanitation can also weaken children and expose them to often deadly pathogens. Many of these causes of child death and illness are linked to the health and survival of a child's family, especially the mother. Child illness and death have also been associated with birth intervals less than three or greater than five years. Children born less than two years after a previous sibling are more than twice as likely to die as children born three to five years apart.

Children born three to five years after their preceding sibling have lower risks of neonatal, infant, and under-five mortality compared with children born outside this interval. The risks of stunting and being underweight are also highest among children born at intervals shorter than three years.

When children lose their mother, they lose their primary care giver. Without the love and care of a mother, children are vulnerable to a variety of life-threatening or debilitating circumstances.

A mother's poor health status during pregnancy can result in a stillbirth or a preterm and low-weight newborn. Infants born to mothers with poor nutritional status due to illnesses such as anemia have an increased risk of being born HIV-positive or infected with malaria. These babies are also more likely to be born at a low birthweight and can more easily acquire HIV, thereby increasing their risk of illness and death.

Use of family planning can reduce deaths and disabilities from maternal causes and help women space births. Mothers who are healthy during pregnancy are more likely to give birth to healthy children. Mothers who remain healthy following childbirth are better able to care and provide for their children.

#### KEY POINTS

**Children spaced between three and five years apart face the lowest risks of illness and death.** Appropriate birth spacing is associated with reduced risk of perinatal, neonatal, infant, and under-five mortality. While it is difficult to pinpoint the exact reasons why births spaced three to five years apart are best for children's survival and health, evidence suggests that longer birth intervals allow women to recover physically and nutritionally before the birth of the next child. Mothers who become pregnant while still breastfeeding and caring for a young child may have to wean the child sooner, reducing the child's exposure to the nutritional and immunological benefits of breast milk. As a benefit to older children under age five, spacing births may decrease the risk of death as well as reduce the likelihood of stunting and being underweight. Children also benefit from additional time and nurturing from parents when their sibling is at least three years younger or older. In addition, mothers who are able to time their pregnancies are usually healthier during pregnancy, laying the foundation for a healthy infancy and childhood (Setty-Venugopal and Upadhyay, 2002).

**Children who have lost their mother or whose mother is ill are at risk of death and illness.** Short birth intervals can leave a woman nutritionally or otherwise unhealthy and increase her risk of death. Maternal orphans and children whose mother is ill or nutritionally unhealthy may not receive the necessary nutritional and immunological benefits of breast milk, early medical care, immunizations, and other care needed for a healthy start in life. Older children also rely on their mother for

nutrition and access to illness prevention and treatment (Tinker and Ransom, 2002).

**PMTCT programs can improve the survival of both mothers and their children.** HIV/AIDS continues to kill women, infants, and young children around the world, especially in African countries with exceptionally high levels of HIV/AIDS and limited health services. This scenario is now increasingly true in many parts of Asia where the epidemic is moving from high-risk groups to the general population. Voluntary counseling and testing services for couples, along with high-quality antenatal, delivery, and postpartum care that includes antiretroviral therapy and family planning services, can provide women and men with the necessary information and commodities to make informed healthcare decisions for themselves and their family. Specifically, family planning services can help HIV-positive women determine and meet their future fertility goals. Family planning methods such as male and female condoms can reduce the risk of HIV transmission during pregnancy, thereby reducing the risk of transmission to newborns.

## STRATEGIES

Strategies to improve child health outcomes through the provision of family planning services to couples include:

- Educating women on the child health benefits of delaying, spacing, and limiting births and providing them with high-quality family planning services to help families meet their fertility goals and improve children's health and survival.
- Promoting the benefits of family planning for child health by educating families and religious and other local opinion leaders who influence fertility decisions in order to encourage the use of family planning and make it a social norm.
- Providing family planning services alongside HIV/AIDS voluntary counseling and testing services to provide individuals with the information and commodities needed to prevent HIV/AIDS transmission and make future fertility decisions. Integrated maternal health and VCT services can also provide women with the healthcare services needed to reduce mother-to-child transmission of HIV/AIDS.

- Working and advocating with child health partners not usually involved in family planning to expand opportunities to promote the child survival benefits of spacing. Efforts may include working with pediatricians and nurses to discuss birth spacing with parents during child health visits and referring parents to appropriate services.
- Advocating to national political leaders to fulfill commitments to family planning and child survival made by the host country at international forums.

## ILLUSTRATIONS

The CATALYST Consortium, a USAID-assisted program that promotes optimal birth spacing, encouraged the use of family planning in settings usually averse to family planning messages, while simultaneously promoting a change in social and cultural norms. For example, in India, Nepal, and Pakistan, countries with a preference for male children, the consortium developed a message about birth spacing to improve the health of all future male or female children and to promote the benefits of healthy children rather than closely spaced children.

The CATALYST Consortium also produced projections regarding the number of deaths among children under age five that would be averted if no births were to occur before 36 months of the preceding birth. Overall, in less-developed countries (excluding China), if no births were to occur within 36 months of the preceding birth, the infant mortality rate would decrease by 24 percent and the under-five mortality rate by 35 percent, and 2,875,000 deaths to children under five would be averted annually.

A mother's health during pregnancy can affect her child's health and survival. Short birth intervals adversely affect a mother's energy, weight, and body mass index. Poor maternal nutritional status can then affect the nutrition and growth of the fetus, resulting in premature birth, low birthweight, impaired growth, and poor nutrition for the infant. These conditions are risk factors for impaired cognitive development and developmental challenges, illness, and even death (CATALYST Consortium, 2004; 2005).

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## SECTION SIX POSTABORTION CARE

### ISSUE

The World Health Organization (WHO, 2000) estimates that 19 million unsafe abortions cause 50,000 to 100,000 deaths each year, about 13 percent of total maternal deaths. Many of the remaining women, approximately 10 to 50 percent, need medical care for treatment of postabortion complications. Even though many countries recognize the importance of postabortion care (PAC) services, they usually do not provide them systematically or effectively, leaving many women without access to such services.

The most common complications following abortion are incomplete abortion, sepsis, hemorrhage, and intra-abdominal injury. With the exception of intra-abdominal injury, all complications can result from either spontaneous abortion (miscarriage) or induced abortion and, left untreated, can result in death. In addition, women who survive immediate postabortion complications may suffer life-long disability or face elevated risk of complications in future pregnancies. A pregnancy occurring less than six months after an abortion could endanger both mother and child. Postabortion interpregnancy intervals of less than six months are associated with low birthweight, preterm delivery, maternal anemia, and premature rupture of membranes.

### KEY POINTS

**Family planning plays a critical role in preventing maternal and child deaths and illness related to postabortion complications and short postabortion interpregnancy intervals, including ectopic pregnancies and miscarriages.** Prevention of unintended pregnancies reduces the number of abortions and therefore reduces the number of women experiencing complications, leading to fewer maternal deaths from postabortion complications. In addition, as compared with women with an interpregnancy interval of 18 to 23 months,

women with short interpregnancy intervals of less than six months following an abortion are at an increased risk of delivering a low-birthweight baby, delivering a preterm baby, experiencing maternal anemia, and experiencing premature rupture of membranes (Conde-Agudelo et al., 2005).

Family planning and VCT services should be an essential component of PAC services. Providing women with information and family planning options before they are released from the healthcare setting can prevent future unintended pregnancies, abortions, and pregnancy as well as infant health complications associated with short postabortion interpregnancy intervals. Family planning services can also help women reach fertility goals. Providing women with VCT services immediately following an abortion may lead to behavior changes resulting in more women using family planning methods and a reduction in the transmission of HIV from mother to child.

**Social issues surrounding abortion, as well as penalties for abortion providers and women who undergo abortions, restrict access to PAC services even when legal.** Family members may delay treatment for a woman suffering from abortion complications for fear that they will be reported to authorities. Delays may lead to misdiagnosis or delayed and inappropriate treatment if women do not inform health providers that they underwent an abortion.

**Many health facilities in developing countries are understaffed and have inadequate budgets.** In many countries, high demand for postabortion emergency treatment consumes valuable healthcare facility bed space and resources. In addition, the lack of specific protocols and treatment guidelines for PAC patients may lead to delayed or inappropriate treatment.

**Provider attitudes, regardless of the legality of abortion, often discourage women from seeking services.** When women seek PAC services, some providers “punish” them by delaying treatment, refusing pain medication, or charging inordinately high fees.

## STRATEGIES

Treatment of postabortion complications and prevention of both unintended pregnancies and abortions are essential for decreasing maternal deaths due to complications of abortions. A comprehensive PAC strategy will reinforce emergency medical care at health facilities while focusing on prevention, including family planning.

The PAC Consortium, an interagency group that advocates for postabortion care services, has developed a model that includes high-quality, comprehensive PAC services. The model calls for the following strategies (Postabortion Care Consortium Community Task Force, 2002):

- Creating community and service provider partnerships dedicated to preventing unintended pregnancies and abortion complications, mobilizing resources, and providing a venue for community input into services.
  - Counseling women who are experiencing complications in order to prevent future abortions and encourage family planning.
  - Providing treatment for complications by, for example, training providers in manual vacuum aspiration (MVA) to treat incomplete abortions. Lower-level trained providers can use MVA technology in low-resource settings; MVA uses local instead of general anesthesia, saving money and valuable resources.
  - Offering contraceptive and family planning services to prevent unintended pregnancies and thereby reducing the number of abortions and postabortion complications.
  - Providing and referring women to reproductive and other healthcare services such as STI/HIV prevention education, screening, diagnosis and treatment, treatment and referral for survivors of gender-based violence, nutrition and hygiene education, and cancer screening and referral based on a woman’s needs, with services ideally offered on site so that a referral system is not needed.
- Decentralizing PAC services to reduce delay in receiving care and establishing referral systems.
  - Creating a training component that discusses provider attitudes and develops strategies for addressing PAC.

## ILLUSTRATIONS

Between 2000 and 2002, the Senegalese Ministry of Health and partner organizations, including the Population Council’s USAID-supported Frontiers in Reproductive Health Project, undertook a program to demonstrate that PAC services could be performed at rural, low-level health facilities where the majority of complications were treated, thereby reducing maternal death and disability from abortion complications. The MOH and its partners introduced a variety of quality improvement interventions at 18 district health centers and health posts. At district health posts, where patients are referred and receive treatment for PAC, the program trained doctors and midwives in the management of abortion complications, including the use of MVA with local anesthesia. Before the start of the program, only one-third of these providers were skilled in addressing abortion complications. Health center staff from both district health centers and health posts received training in PAC, family planning, other reproductive health counseling, and contraceptive technologies. At the end of the training, integrated PAC services were available at all district health centers. At the end of 14 months, the number of PAC cases treated at the centers increased by 23 percent, reflecting more than a doubling of referrals from lower-level health posts. More than half of all complications were also treated with MVA with anesthesia. Seventy percent of PAC clients received family planning counseling as compared with 38 percent before the intervention, and 20 percent of clients left the health facility with a modern contraceptive as compared with zero women before the intervention. However, counseling quality did not change, with little progress in clients’ knowledge of pregnancy risk after abortion and in the number of clients receiving reproductive healthcare counseling (Population Council, 2004b).

In Russia, where abortion is a common fertility control measure and a major cause of maternal mortality and morbidity, the Russian Center of Obstetrics, Gynecology, and Perinatology along with its partner organizations took part in an operations research study undertaken by



the USAID-supported Frontiers in Reproductive Health Project to study the effects of improved postabortion services. The research compared the effects of two models of postabortion family planning service delivery on reducing the approximately 40 percent repeat abortion rate. In both models, health providers were trained in family planning counseling and interpersonal communication. They also developed and were supplied with job aids and education materials on postabortion family planning. The second model also offered clients a free three-month supply of contraceptives or an IUD. After the training, both providers and clients demonstrated increased postabortion family planning and fertility knowledge. Under the model providing contraceptives, providers were more likely than those working under the model without contraceptives to discuss family planning with PAC clients, though family planning use among these clients did not significantly increase within one year following an abortion. The study did demonstrate that family planning counseling during the postabortion follow-up visit was important in reducing repeat abortions. The initial findings from the operations research study influenced the development of the first National PAC Service Delivery Guidelines for Russia in 2003.

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## CHAPTER 2

# FAMILY PLANNING AND MACRO-LEVEL IMPACTS



S. COLVEY/IDRC

Global meetings and resulting declarations, such as the International Conference on Population and Development's (ICPD) Program of Action and the Millennium Development Goals (MDGs), can spur policy change directed to the realization of political or economic goals. Achievement of the objectives outlined in the ICPD Program of Action and MDG declarations depend on improved family planning services. The human capital theory discusses achieving optimal health of individuals, including optimal reproductive healthcare in order to reach optimal social and economic productivity. The demographic dividend theory provides an economic rationale to increase access to and use of family planning methods. This section outlines the relationships among family planning, the ICPD Program of Action and MDGs, human capital, and the demographic dividend.

## SECTION ONE

# GLOBAL DECLARATIONS—ICPD PROGRAM OF ACTION AND MILLENNIUM DEVELOPMENT GOALS

### ISSUE

In 1994, the International Conference on Population and Development (ICPD) in Cairo brought together representatives from 179 nations to outline broad 20-year goals for reproductive healthcare, gender equality, and population stabilization, specifically as related to the world's age structure and population growth rate.<sup>8</sup> In 2000, the international community agreed to the goal of reducing by half the number of people living in absolute poverty by 2015 through the achievement of eight MDGs (The Alan Guttmacher Institute and UNFPA, 2004). The MDGs are similar in spirit to the ICPD Program of Action goals, calling for improvements in areas such as maternal health, universal primary education, and empowerment of women. A review of the ICPD and MDG documents reveals that improvements in family planning are required to achieve the goals specified in these declarations.

### KEY POINTS

**The ICPD Program of Action and MDGs express a strong commitment to dramatically improving family planning, reproductive health, child health, and gender indicators.** The two policy documents outline specific goals for reducing maternal mortality, combating HIV/AIDS, reducing child mortality, allowing universal access to reproductive healthcare, and ensuring gender equality, equity, and empowerment.

**The ICPD Program of Action and the MDGs call for a reduction in maternal mortality by 75 percent by 2015 and a reduction in HIV/AIDS infection rates.** More specifically, the ICPD sets forth a goal of reducing

by 25 percent the HIV infection rates for persons age 15 to 24 by the year 2010 in the most affected areas as well as globally. The MDGs set forth a goal of stopping the spread of HIV/AIDS, malaria, and other diseases by 2015 and call for a reduction in under-five child mortality by two-thirds by 2015. The ICPD sets no quantitative targets for child mortality.

**The ICPD Program of Action endorses universal access to reproductive healthcare.** The ICPD declaration is based on recognition that couples and individuals should be able to determine freely and responsibly the number and spacing of children.

**The ICPD Program of Action states that gender equality and equity and women's empowerment are ends in themselves.** The ICPD calls for involving women fully in decisionmaking processes, policy development, and all aspects of economic, political, and cultural life (UNFPA, 1994). The MDGs discuss equity and women's empowerment, albeit with a narrowly focused target indicator.

### STRATEGIES

Reaching the goals set out in the MDGs will require resource and political commitments from national governments and donors. The strategies for achieving these laudable goals include:

- Increasing access to high-quality family planning services. As explained in Chapter 1, the use of family planning is essential to reducing both maternal and child mortality and illness. In most countries of sub-Saharan Africa, family planning use remains low, and efforts to decrease maternal and child mortality have shown only limited progress. In South Asia, modern contraception is most commonly used to limit fertility rather than to delay risky births in adolescence or to space births.

8. All discussion on the contents and commitments of the ICPD declaration pertain only to those countries where the declaration has been signed. The United States government supports many of the goals in the ICPD Program of Action contingent on several understandings, in particular that the ICPD documents do not create international legal rights, including any right to abortion, nor do they create any legally binding obligations on states under international law.

- Advocating for international political and financial commitments to combat the HIV/AIDS epidemic in order to promote the integration of HIV/AIDS and family planning services. Although the role of male and female condoms in reducing the transmission of HIV is widely known and generally accepted, proposals for integrating many aspects of the HIV/AIDS strategy into family planning programs have not been forthcoming.
- Promoting birth spacing to improve child survival and meet the related MDG. Progress in reducing child mortality is on track or nearly so in North Africa, Latin America, the Caribbean, and Southeast Asia, while progress has been slower in sub-Saharan Africa and West Asia. In many of the countries in West Asia, the use of contraception for birth spacing is not common.
- Urging governments to foster a climate that is favorable to the provision of high-quality family planning services.
- Ensuring that a woman's ability to regulate fertility will play a key role in her ability to participate more fully in political, social, and economic activities.

## ILLUSTRATION

Five years have passed since world leaders adopted the United Nations (UN) Millennium Declaration and the MDGs, and 10 years remain to achieve the goals (see Table 1). For the most part, the technologies and interventions necessary to meet the MDGs are available; the missing component is national government and donor commitment to expand programs and apply the available knowledge on a global scale. Realization of the MDGs is tantamount to developing human capital, fostering economic growth, and reducing poverty. Achieving the goals is also important to attaining international security and stability and meeting human rights. In January 2005, the Millennium Development Project, an advisory body to the UN Secretary General, released a report outlining a plan and recommending priorities for achieving the MDGs. The report, titled *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*, as well as several task force reports on specific MDGs, describe progress in meeting the MDGs. Especially as related to women's health and gender equity goals, the results thus far are mixed. For example, some countries, including many countries in sub-Saharan Africa and South Asia, will not meet the 2005 interim goal for gender parity in education. Maternal mortality remains high across developing regions, and HIV/AIDS continues to threaten the lives of women and their families around the world, but especially in southern Africa.

**Table 1. Millennium Development Goals and Targets**

<b>Goal 1:</b> Eradicate extreme poverty and hunger	Target 1: Reduce by half, between 1990 and 2015, the proportion of people whose income is less than \$1 a day
	Target 2: Reduce by half, between 1990 and 2015, the proportion of people who suffer from hunger
<b>Goal 2:</b> Achieve universal primary education	Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary school
<b>Goal 3:</b> Promote gender equality and empower women	Target 4: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015
<b>Goal 4:</b> Reduce child mortality	Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate
<b>Goal 5:</b> Improve maternal health	Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate
<b>Goal 6:</b> Combat HIV/AIDS, malaria, and other diseases	Target 7: Halt by 2015 and begin to demonstrate reversal of the spread of HIV/AIDS
	Target 8: Halt by 2015 and begin to demonstrate reversal of the incidence of malaria and other major diseases
<b>Goal 7:</b> Ensure environmental sustainability	Target 9: Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources
	Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation
	Target 11: Achieve by 2020 significant improvement in the lives of at least 100 million slum dwellers
<b>Goal 8:</b> Develop a global partnership for development	Target 12: Develop further an open, rule-based, predictable, nondiscriminatory trading and financial system (including a commitment to good governance, development, and poverty reduction) both nationally and internationally
	Target 13: Address the special needs of the Least Developed Countries (includes tariff- and quota-free access for Least Developed Countries' exports, enhanced program of debt relief for heavily indebted poor countries [HIPC] and cancellation of official bilateral debt, and more generous official development assistance for countries committed to poverty reduction)
	Target 14: Address the special needs of landlocked developing countries and small island developing states (through the Program of Action for Sustainable Development of Small Island Developing States and 22nd General Assembly provisions)
	Target 15: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term; some indicators are monitored separately for the least developed countries, Africa, landlocked developing countries, and small island developing states
	Target 16: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth
	Target 17: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries
	Target 18: In cooperation with the private sector, make available the benefits of new technologies, especially information and communication technologies

Source: UN Millennium Project. 2005. *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*. New York: UNDP.

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## SECTION TWO

# REPRODUCTIVE HEALTH AND HUMAN CAPITAL

### ISSUE

The 1994 International Conference on Population and Development (ICPD) was the culmination of a shift in the rationale for and role of population policy. The focus changed from reducing population growth to meeting people's basic reproductive healthcare needs. The shift in focus has provided an opportunity to highlight the favorable economic impacts of reproductive healthcare on the individual and the household. Human capital theory can show policymakers that improving the reproductive health of citizens benefits the public interest by increasing the potential productivity of individuals, families, or households, which, in turn, increases society's productive potential.

During the 1950s and 1960s, the primary framework for understanding economic growth was the production function, which describes a process whereby inputs (machines, labor, natural resources, and so forth) combined with technology result in outputs. Based on this framework, the solution to underdevelopment was to increase the amount of inputs, thus increasing the amount of outputs. However, empirical studies found that not all growth could be explained by the inputs. In other words, a factor of production or input was missing. Further investigation revealed that differential intrinsic qualities of labor explained much of the unexplained output.

Human capital is defined as “any quality specific to and undetachable from a person that allows her (or him) to perform economic tasks more efficiently, vigorously, or consistently—or allows her (him) to lead a happier life” (Seligman et al., 1997). Human capital is a nonmaterial input that pertains to an individual, such as skills, training, experience, knowledge, and so forth. In the context of health, human capital can be good general health and/or the absence of disability.

Human capital in the form of good general health contributes to economic growth by supporting the following pathways:

- Reducing production losses due to worker illness.
- Permitting the use of natural resources that were previously inaccessible due to disease (e.g., the cultivation of fertile riverside land after the eradication of river blindness).
- Increasing children's school enrollment and enhancing their ability to learn.
- Freeing up public and private resources that would have been allocated to treating illness.

Improved reproductive health also improves the first, third, and fourth pathways.

### KEY POINTS

**Improvements in reproductive health have consequences at the individual, family, and household levels (micro level).** Reproductive health increases the human capital of women who directly contribute to socioeconomic development. Indirectly, reproductive health increases the human capital of children by keeping their mothers alive.

**Improvements in reproductive health have consequences at the societal level (macro level).**

Women with access to family planning information and methods and to other social services such as education and healthcare can control their reproductive outcomes and typically give birth to fewer children (Tsui, 1991, referenced in Seligman et al., 1997). Fewer births in turn slow population growth, which relieves some pressure on natural resources and overstretched public services.

**Safe, effective, and affordable reproductive healthcare provides women with the opportunity to enjoy both nonreproductive and reproductive roles in society, thereby contributing directly to socioeconomic development through increased per capita income.** When women have the opportunity to

assume nonreproductive roles in society, they increase their productivity both in and out of the household and enhance the quality of time they spend with their children, increasing their children's human capital (Seligman et al., 1997).

**Promotion of a mother's reproductive health influences the formation of her children's human capital by encouraging smaller family size and greater attention to child development.** Parents with fewer children are more able to invest significant time, typically the mother's time, and other resources in each child than parents with more children.

**Investments that promote reproductive health improve a woman's human capital by contributing to her knowledge, reducing family size and promoting child development, promoting the health of the mother and child, promoting the nutritional status of the mother, and empowering women.** Knowledge helps women work smarter and be better caretakers of their children. Reduced family size allows a woman to spend more time on activities that directly improve her human capital or help her children develop mentally and emotionally. Better health status improves the level of effort a woman is able to put forth in productive activities or activities associated with the improvement of her children. Good nutritional status provides women with the ability to ward off future or proximate health problems and, on a daily basis, influences women's activities depending on their caloric intake. Empowering women provides them with economic opportunities that enhance their ability to benefit from other social investments such as education and family planning programs.

**Social programs benefit more than the individual who consumes program services.** To understand the full effects of a program, it is essential to take into consideration others who may benefit from an individual's participation in a particular program. For example, iron supplements directly affect the nutritional status of a woman by preventing iron-deficiency anemia. Prevention of iron-deficiency anemia prevents anemia-related maternal complications, thus reducing maternal mortality and morbidity and improving maternal health status. In addition, anemia prevention decreases the risk of a low-birthweight baby, thus increasing the prospects of child survival. If both mother and child have sufficient iron, the child will be better able to learn, leading to a positive

effect on knowledge. Finally, reducing infant mortality due to iron deficiency will reduce fertility as the child will not have to be replaced, thus affecting family size and child development.

## STRATEGIES

Increasing human capital by improving reproductive health involves the following strategies:

- Increasing access to education for women and children by, for example, ensuring adequate teachers, facilities, and equipment and, in some places, adapting sociocultural norms to promote education, especially among women.
- Increasing access to and use of family planning information and methods to promote smaller families and, indirectly, child development.

## ILLUSTRATIONS

In 1990, a study conducted in two rural sites in Thailand examined the perceived and objective impacts of the number of children on a couple's socioeconomic well-being. The qualitative data collection extended to both small and large families. The study found that while reproduction does not prevent rural Thai women from working, it does temporarily interrupt economic activity. Women included in the study were prevented from participating in economic activity for an average of three months following the birth of a child, after which time they returned to work, though probably with decreased intensity. Overall, for women with large families, the median length of economic inactivity during their entire reproductive life spanned 19.3 months compared with 9.1 months for women with smaller families. Focus group discussions revealed that women with younger children did return to work, but caring for these children often interfered with their work, most notably during the breastfeeding period. The effect of interference by children extends beyond mothers to fathers, who find that they have to provide assistance with child care and household chores in addition to working outside the home. Furthermore, the study found that, in part, the presence of children dictated the type of work in which a woman can engage; for example, a breastfeeding woman cannot undertake wage labor (mostly agricultural or handicraft) and instead engages in economic activities outside the home only if it is possible to bring her children to work.

The study's main finding is that, for rural Thai women, it is less a question of whether women work during their reproductive years and more a question of how much they can work and how economically productive they are during these years. The study indicates that women can do more work if their family size is small. Ninety-five percent of women with small families reported that they would have worked less if they had four or more children while 90 percent of women with large families reported they would have worked more if they had only two children. By providing and promoting accessible family planning services, women in rural Thailand can minimize family size and increase their economic participation and productivity (Poshisita et al., 1990).

The University of North Carolina, Family Health International, and the University of San Carlos in Cebu, Philippines, conducted a study to assess the impact of childbearing on the likelihood that a woman would participate in the labor force and, once in the labor force, the impact of employment on her earning power (Adair et al., 2002). A baseline survey conducted in 1983 found that 46.6 percent of women in their sixth or seventh month of pregnancy were working for pay at the time of data collection or had worked for pay in the previous four months. The follow-up survey in 1991 found that 73.9 percent of the sampled women were working for pay. After controlling for inflation, the study found that the average

change in earnings from 1983 to 1991 was 47 pesos per week as reflected by the increase in the number of hours worked from 41.6 in 1983 to 46.1 in 1991. The study also found that one additional child decreased a woman's total weekly earnings by 11 pesos per week and that four or more children decreased weekly earnings by 56 pesos per week. While the effect of childbearing on earnings was associated with hours per week worked, childbearing still had an effect on earning after controlling for hours, indicating that women likely shifted to lower-paying jobs that may have been more compatible with childbearing and childrearing.

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## SECTION THREE

### THE DEMOGRAPHIC DIVIDEND

#### ISSUE

The term “demographic dividend” refers to the potential economic benefit of reduced fertility and other changes in a population’s demographics. The demographic dividend begins with a fall in the infant mortality rate and an increase in life expectancy and ends with economic growth. A reduction in infant mortality creates a relatively rapid increase in the number of children surviving to adulthood. Falling infant mortality rates often coincide with increases in life spans as nations move from a situation of high infectious disease burdens with accompanying high death rates to chronic disease with lower death rates. As societies move through this “epidemiological transition,” fertility rates often fall, and people live longer lives. The initial increase in child survival followed by decreases in fertility and increases in life spans can leave societies in a potentially advantageous position (Ross, 2004).

A generation following the initial increase in child survival, the proportion of the population of working age adults becomes larger than the proportion of dependents (children and elderly). When the population dependency ratio decreases, the working age cohort is able to increase its personal savings. When combined with the appropriate macro-economic policies, the increase in savings can lead to economic growth. As life spans increase, individuals are able to work longer, further contributing to economic growth. This scenario of a decreasing dependency ratio and increased savings may create a situation whereby the education of existing children is favored over increased family size. It is apparent that the initial fertility decline generates greater income, which may further lower fertility. While it is not clear what is responsible for the initial fall in fertility, family planning can promote and foster the fertility decline and thus hasten the change in the population’s age structure.

#### KEY POINTS

**For the demographic dividend to be realized, family planning efforts must be combined with additional infant mortality prevention measures and growth-promoting economic policies.** The demographic dividend comes about not merely by a decrease in the fertility rate but also through an increase in the number of surviving children as a consequence of a reduction in the infant mortality rate followed by a decline in the fertility rate. In addition, without sound economic policies and improvements in health status and educational achievement, a society will not be prepared and persons will not be able to participate fully in the economic potential of the demographic dividend.

**Fertility rates may increase and the demographic dividend go unrealized if individuals do not acknowledge the likely increase in income from smaller family size.** Fertility will likely remain low if increases in income induce a desire for greater human capital investment, including an investment in children’s education and healthcare. Smaller families also mean greater returns on human capital investment in girls and women. With fewer children, women reduce their maternal mortality and disability risks and are able to participate and contribute to society by working in the labor force and devoting time to the family.

**The size of an economy is related to a population’s dependency ratio.** The gross domestic product (GDP) is positively influenced by a greater proportion of working-age to nonworking-age individuals in a society. The population growth rate itself does not influence the GDP.

## STRATEGIES

The following strategies could place nations in a better position to reap the potential benefit of the demographic dividend:

- Ensuring that the appropriate macroeconomic policies are in place to help an economy absorb an increase in working-age adults. The existence of high-quality institutions and an openness to trade are two proxy measurements for beneficial policies. In countries with low-quality institutions and little openness to trade, the effect of demographic shifts is minimal.
- Promoting access to and use of high-quality family planning services to ensure a low dependency ratio by improving child survival and helping couples reach desired family size.
- Investing in the health of children not only to improve their chances of survival but also to improve their educational performance.
- Improving contraceptive security to help the health sector keep pace with rising demand for family planning and the desire for smaller families that potentially follows economic growth, particularly in the emerging economies of South Asia, Southeast Asia, the Middle East, and East Africa.
- Improving the quality of education and promoting education of all children to help individuals reach their full potential and lower desired family sizes and increase the demand for family planning as parents strive for better education of all their children and as educated women delay the onset of childbearing. The income potential of education can also influence educational investment at the family level.

## ILLUSTRATION

The large share of evidence linking demographic change with economic growth comes from research on the rapid change in economic status in East and Southeast Asian countries during the late 1980s and early 1990s. Limited evidence points to a direct causal link between good health status or use of family planning and economic growth. Good health maximizes returns on human capital investments such as in education, and the use of family planning contributes to declines in fertility and resultant decreases in dependency ratios. Richard Cincotta and

Robert Engelman (1997), in their report titled *Economics and Rapid Change: The Influence of Population Growth*, describe how rapid declines in fertility during the 1970s and 1980s in South Korea, Taiwan, Singapore, the former Hong Kong Territory, Thailand, Indonesia, and Malaysia were related to the economic prosperity experienced by these countries in the 1990s. The fertility declines were partially attributable to access to family planning services, later age at marriage, and increases in women's educational opportunities. The authors also note that strong government commitment to promulgating and enforcing health, economic, and public education policies contribute to economic growth. David Bloom and others in their paper titled "Demographic Change and Economic Growth in Asia" (1999b) also describe how decreased fertility rates in East Asia led to low dependency ratios and increased personal savings in the region. Increased life expectancies during the same period affected savings rates as people recognized the need to save for old age, and longer life spans allowed individuals and society to continue to recoup benefits from earlier human capital investments.

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## CHAPTER 3

# FAMILY PLANNING AND THE PREVENTION OF MOTHER-TO-CHILD TRANSMISSION



The majority of HIV-positive women are between the reproductive ages of 15 to 49. These women could potentially pass on the HIV infection to their children through mother-to-child-transmission (MTCT). Indeed, without any medical intervention, including the use of family planning, 30 percent of them will pass the virus to their fetus or newborn. HIV-positive women and their partners need to be informed of their family planning options so that they can make educated decisions about their reproductive future. This chapter includes sections on expanding access and contraceptive choice for HIV-positive women and the costs and benefits of integrating family planning and prevention of mother-to-child-transmission of HIV (PMTCT) services.

## SECTION ONE

### EXPANDING ACCESS AND CONTRACEPTIVE CHOICES FOR HIV-POSITIVE WOMEN

#### ISSUE

In many countries, women do not know their HIV status for a variety of reasons; in many cases, they have little or no chance of obtaining life-saving ARV treatment for themselves or they fear becoming a victim of discrimination within the family and community. Many women are offered testing during routine antenatal visits, but decline the testing or do not return for the results. Testing of male partners is not customary in most countries.

Providing for the family planning needs of HIV-positive women and of those with unknown status is an essential component in the fight against the spread of HIV. The majority of HIV-positive women are between the ages of 15 and 49, representing the prime reproductive ages. The virus is passed to 25 to 35 percent of infants born to HIV-positive women if no treatment is available or provided.

Preventing and/or limiting the number of pregnancies among positive women have many health, social, and economic benefits for the woman, her family, and the community. At the societal level, reducing the number of unintended pregnancies among positive women will help reduce the long-term burden on the healthcare system by reducing the number of HIV-positive births. At the individual and family levels, HIV-positive women suffer from increased maternal mortality and morbidity as a consequence of a compromised immune system, poor nutritional status, chronic anemia, opportunistic infections, and co-infection of malaria. For those positive women and their partners who choose to have children, they need the information and services required to plan and time a safe pregnancy and delivery. Other HIV-positive women may wish to delay or prevent future pregnancies; for them, family planning services and methods are similarly crucial. Depending on the stage of the HIV-progression, nutritional status and presence of co-infections, a pregnancy can further compromise the fragile immune system of a positive woman. For those positive women and families desiring children, family

planning can help them plan for the optimal timing to space pregnancies and give birth and to obtain access to ARV treatment, which increase the chance of maternal and infant survival. Babies born to HIV-positive mothers often develop problems in utero such as anemia and malaria or growth retardation and toxic effects from some forms of ARVs that the woman may be taking to prevent progression of her own disease process. Short- and long-term effects of ARV toxicity in utero are associated with stillbirth, premature birth, low birthweight, failure to thrive syndrome, along with the other health and survival risks.

#### KEY POINTS

**Contraception can be safe for HIV-positive women; however, not all methods are appropriate.** The IUD is an effective female-controlled method, but providers may discriminate against HIV-positive women and refuse to insert IUDs out of fear of becoming infected. Providers' fear of infection may also limit women's access to sterilization procedures, another effective long-term method of contraception. Training providers in correct IUD insertion and sterilization methods and providing them with the necessary supplies to take universal precautions can remove such barriers.

Hormonal methods such as pills and injectables may potentially interact with ARVs resulting in either a decrease or increase in the bioavailability of the steroid hormone in hormonal methods. There is limited data that suggest that drug interactions between many ARVs and hormonal contraceptive methods may alter the safety and effectiveness of both treatments. Current WHO eligibility criteria place the use of all contraceptive methods for patients on ARVs in Category 2 indicating that, in general, women on ARVs can use any contraceptive method. The exception is for IUDs, which fall into Category 3 for insertion, indicating that use of the method is not usually recommended unless other more appropriate methods are not available or acceptable, and



Category 2 for continuation. However, if the woman is clinically well on ARV therapy, both IUD insertion and continuation are considered Category 2. Multicountry research is currently under way to study remaining concerns on the interaction between ARVs and hormonal contraception. Hormonal methods are also more costly because of the need to resupply.

Condoms offer dual protection from pregnancy and HIV infection, but, as a male-controlled method, many women lack the level of control necessary to ensure protection. Female condoms offer women relatively more control than male condom use. However, negotiating condom use remains a barrier to use for some women along with prohibitive costs and other inconveniences.

Both HIV-positive women and men should be involved in creating and implementing programs that provide contraceptive methods to HIV-positive individuals. Such participation promotes education of both clients and providers and can help minimize barriers to services.

**Policies restricting the performance of procedures by certain healthcare providers may also limit method choice.** Although studies have shown that midwives and nurses are able to perform IUD insertions with no adverse effects, many countries' operational policies allow only physicians to insert IUDs. Increasing the number of healthcare workers authorized to provide services will increase access and expand choice.

**Information barriers often limit family planning method choice and availability for HIV-positive women.** Providers often do not explain to HIV-women the range of pregnancy-related risks to both them and their unborn children. Moreover, providers' belief that HIV-positive women should not be sexually active limits the information offered to these women. Providers must respect the rights of HIV-positive women and make comprehensive information available to them so that they can make informed choices, whether they choose to conceive or prevent unintended pregnancies.

Although family planning to prevent unintended pregnancies is necessary, the needs of women who choose to become pregnant are also important. Support and counseling, both during pregnancy and after birth, is essential. Access to ARVs, safe birthing methods, and information about alternative feeding methods and breastfeeding precautions is critical.

## STRATEGIES

The following strategies can improve access to family planning information and services to HIV-positive women:

- Providing training and sensitization to healthcare workers to reduce stigma and discrimination toward HIV-positive women seeking family planning, thereby increasing women's access to information about method choice. Healthcare workers who respect an HIV-positive woman's right to be sexually active and make her own reproductive decisions will be more likely to present all of the information a woman needs to make an informed method choice that fits her needs.
- Creating guidelines and increasing safety precautions for healthcare workers treating infected patients to help decrease resistance to performing invasive procedures on HIV-positive women, further expanding HIV-positive women's options. This includes providing training and the necessary supplies for providers to practice universal precautions.
- Expanding the definition of who is authorized to perform procedures involved in contraception, such as IUD insertion and sterilization, in order to increase method availability.
- Continuing investment in the development of female-controlled contraceptive methods to decrease the resistance that many women face during the negotiation of contraceptives with their partner.

## ILLUSTRATION

James Shelton and E. Anne Peterson make the case for linking family planning and ARV services in a November 27, 2004, *Lancet* article titled "The Imperative for Family Planning ART in Africa." The article states that current PMTCT guidelines recognize that reaching out to potential recipients of ARV therapy in resource-poor settings requires several points of entry such as maternal and child health, family planning, and HIV services.

Emergency Plan focus countries such as Botswana, Kenya, and South Africa offer promising examples of health service integration. Integrated ARV and family planning programs increase the number of service delivery points directly offering ARVs and can provide a broad array of services, including family planning. Service integration makes healthcare visits more time-efficient for patients

and helps address the devastating issues and effects of disclosure, stigma, and discrimination. An additional benefit of integrated family planning and ARV services is the creation of a supportive environment conducive to treatment adherence and patient follow-up. Shelton and Peterson also explain that family planning use can reduce the risk of unintended pregnancies, allowing HIV-positive women to focus on their general health as well as on nutrition issues, ARV regimens, and the prevention and treatment of opportunistic infections.

In the African context, Shelton and Peterson cite compelling human, medical, social, and programmatic reasons to make high-quality, highly accessible, effective, and voluntary contraception available to women on ARV therapy. They make the case for rising to the programmatic challenge of scaling up activities to provide ARV drugs to a greater number of people in resource-poor settings and designing programs from the outset to strengthen family planning and other integral health services.

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SECTION TWO

COSTS AND BENEFITS OF ADDING FAMILY PLANNING TO SERVICES TO PREVENT MOTHER-TO-CHILD TRANSMISSION OF HIV<sup>9</sup>

ISSUE

In many parts of the world, high levels of HIV prevalence among women of childbearing age carry a triple tragedy. Not only do these women face the prospect of discrimination, illness, and early death, but they may also pass the HIV infection to their children or leave their children behind as orphans if they die. Efforts are under way for the rapid expansion of programs to prevent adult HIV infections and for improved treatment of those already infected. Programs are also focusing on expanding access to services to prevent the transmission of HIV from mother to child.

Women who learn that they are HIV positive have a special need for family planning services so that they can make informed reproductive decisions. The addition of family planning services at PMTCT sites can double the expected impact of PMTCT on reducing the number of HIV-infected infants and can have an even larger effect on reducing infant, child, and maternal deaths. Preventing unintended pregnancies among HIV-positive women is a primary component of the PMTCT strategy developed by the United Nations and other international donor agencies. In addition, the Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) calls for expansion of PMTCT services to reach 80 percent of pregnant women accessing antenatal care by 2010.

PMTCT programs are generally cost-effective, especially in high-prevalence countries. A recent analysis by John Stover and others found that the expansion of PMTCT programs in 14 developing countries under the U.S. International Mother and Child HIV Prevention

Initiative, now included in the President’s Emergency Plan for AIDS Relief (see Table 2) would cost about \$45 million in 2007 to avert approximately 40,000 new HIV infections and about \$1,300 per child infection averted (see Table 3).

**Table 2. Countries in the U.S. International Mother and Child HIV Prevention Initiative, now included in the President’s Emergency Plan for AIDS Relief**

Botswana	Kenya	South Africa
Côte d'Ivoire	Mozambique	Tanzania
Ethiopia	Namibia	Uganda
Guyana	Nigeria	Zambia
Haiti	Rwanda	

9. Text adapted from Stover, J., N. Fuchs, D. Halperin, A. Gibbons, and D. Gillespie. 2003. Unpublished. “Costs and Benefits of Adding Family Planning to Services to Prevent Mother-to-Child Transmission of HIV (PMTCT).” Paper available from Futures Group.

**Table 3. Impact of PMTCT and Family Planning Services in 2007 in the 14 Countries in the U.S. International Mother and Child HIV Prevention Initiative**

	Child HIV Infections Averted	Child Deaths Averted	Orphans Averted	Mothers' Lives Saved
<b>Nevirapine</b>				
PMTCT	46,000 (34,000–57,000)*	23,000 (17,000–28,000)		
PMTCT cost per event averted	\$2,100 (\$1,500–\$2,400)	\$4,200 (\$2,900–\$4,900)		
Family planning at PMTCT sites	32,000 (27,000–36,000)	87,000 (68,000–106,000)	108,000 (93,000–122,000)	12,000 (10,000–15,000)
Family planning cost per event averted	\$890 (\$600–\$1,110)	\$310 (\$240–\$380)	\$260 (\$180–\$320)	\$2,200 (\$1,700–\$2,700)
<b>AZT + Nevirapine</b>				
PMTCT	80,000 (36,000–93,000)	40,000 (32,000–47,000)		
PMTCT cost per event averted	\$1,200 (\$1,000–\$1,400)	\$2,400 (\$1,900–\$2,800)		
Family planning at PMTCT sites	19,000 (16,000–22,000)	80,000 (62,000–97,000)	119,000 (102,000–135,000)	12,000 (10,000–15,000)
Family planning cost per event averted	\$1,510 (\$1,000–\$1,890)	\$340 (\$270–\$430)	\$240 (\$160–\$300)	\$2,200 (\$1,700–\$2,700)

\* Note: Ranges for output values are shown in parentheses and represent plus/minus two standard deviations. They are based on 1,000 Monte Carlo simulations using parameter values evenly distributed across the ranges noted in the text.

PMTCT programs are being implemented and scaled-up in many countries at the national and subnational levels after years of analyzing smaller-scale pilot projects. Financial and therapeutic resources are now entering the healthcare system in many countries, specifically for large-scale PMTCT programs. The provision of family planning to prevent MTCT provides an opportunity to avert as many new maternal-to-child infections as possible. Thus, family planning can be a cost-effective investment for enhancing the benefits of PMTCT programs.

## KEY POINTS

The following are key points and assumptions taken into consideration in calculating the cost-benefit impacts of providing integrated family planning and PMTCT services:

**Integration of family planning services at PMTCT sites can help HIV-positive women and their partners prevent future unintended pregnancies.** Offering family

planning services at PMTCT sites would greatly expand family planning access and increase the number of both HIV-positive and HIV-negative family planning users. PMTCT sites would serve new family planning users as well as current or previous family planning users who received services from another source. According to DHS reports, 16 percent of women in the 14 U.S. International Mother and Child HIV Prevention Initiative countries have an unmet need for family planning for birth spacing and 9 percent have an unmet need for limiting births. Given that family planning availability is only one factor influencing unmet need, it is assumed that HIV-negative clients who accept family planning offered at PMTCT sites have half the level of unmet need (range 25 to 75 percent). It is possible that HIV-positive women, on the other hand, may have a greater incentive to accept family planning. Therefore, we assume that they accept family planning at twice the level of unmet need (range 1.5 to 2.5 times) and use it to prevent future pregnancies.

In the absence of family planning use, a fertile woman in union has about an 85 percent chance of becoming pregnant in the following year (Hatcher et al., 2004). It is assumed that PMTCT clients have the same risk of pregnancy since their fertility is already demonstrated. The effectiveness of family planning in averting future births is assumed to be 90 percent.

**Family planning costs can vary widely depending on method, service delivery channel, and contraceptive prevalence.** The United Nations Population Fund (UNFPA) estimated average annual costs per family planning user of about \$22 for IUDs, \$32 for injectables, \$28 for pills, and \$12 for condoms. [It is assumed that the average cost per user would be \$22, with a range of \$12 to \$32.] Costs per user are generally somewhat higher in Africa because of low prevalence, but the addition of family planning to existing PMTCT services would be less expensive than stand-alone programs.

**Currently, antenatal care services are the most common entry point for women and families accessing PMTCT services.** With the increasing availability and affordability of antenatal, delivery, and postnatal services, the number of women attending antenatal clinics who will benefit from VCT and PMTCT programs is expected to expand from 8 percent in 2003 to 50 percent by 2007. The rates of acceptance of PMTCT services are based on recent PMTCT projects in Africa participating in the U.S. International Mother and Child HIV Prevention Initiative. Based on these projects, it is assumed that an average 69 percent of women with access to PMTCT services will agree to be tested. Of those found to be HIV-positive, an estimated 46 percent (average) will accept ARV prophylaxis. However, the average benefits may be understated. It is likely that rates of ARV prophylaxis will increase as programs gain experience and community participation leads to more widespread acceptance of prophylaxis (Stover, 2004).

**Prophylactic ARV treatment is a primary PMTCT reduction intervention with substantial benefits.** Prophylactic treatment with ARVs can reduce the rate of transmission of HIV during gestation and birth from 25 to 13 percent. The average costs of PMTCT interventions listed in Table 3 are based on costs reported for South Africa and include pretest counseling and testing, post-test counseling for HIV-negative women, post-test counseling for HIV-positive women, ARV prophylaxis, and, where feasible and necessary, substitute feeding for six months.

**For some countries, the implementation of an extensive PMTCT program may require additional costs for health system strengthening to upgrade clinics, purchase equipment, train VCT counselors and record keepers, and provide other interventions.** Fixed costs, such as facility maintenance and staff salaries, vary considerably by country and could double or triple total PMTCT program costs. The estimates in Table 3 do not consider these fixed costs because of this variability. PMTCT programs do, however, produce savings for the health sector by reducing the number of infected infants and children in need of long-term care. Savings depend on the level of care (not included in results in Table 3).

## STRATEGIES

Several strategies that have been successful in implementing and scaling up PMTCT programs at the national level are presented below:

- Expanding and strengthening current PMTCT programs to allow more women to access preventive services. Providing PMTCT services through a greater number of health service delivery points will allow more women to access services by decreasing travel time and associated costs. Strengthening the quality of care and types of services available at PMTCT sites will avert death and disability from HIV/AIDS and encourage others to seek out and receive care.
- Including family planning in PMTCT services to expand access to contraceptives and information to both HIV-negative and -positive women and to avert maternal and infant death and illness from HIV/AIDS. Arming HIV-positive women with family planning information and a range of contraceptive methods will allow for informed and effective decisions on future fertility.
- Advocating for national PMTCT guidelines to provide health providers with information on the proper treatment of women with HIV/AIDS and to help prevent transmission of the virus. Guidelines should address use of antiretroviral drugs, safe delivery practices, and infant feeding practices.
- Advocating for additional HIV/AIDS resources and political support to provide the attention and financial support necessary to reduce the incidence of HIV/AIDS and to develop and execute high-quality PMTCT programs.

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## CHAPTER 4

# FAMILY PLANNING AND GENDER EQUITY



CURT CARNEMARK/THE WORLD BANK

Gender equity refers to fairness and justice in the distribution of responsibilities and benefits between men and women. It recognizes that men and women have different needs and power and that these differences should be identified and addressed in a manner that adjusts the imbalance between the sexes. This chapter outlines several of the gender-based obstacles to family planning and provides some strategies for overcoming them.



## SECTION ONE GENDER EQUITY

### ISSUE

For family planning efforts to ensure that women and men are able to reach their family planning goals as effectively as possible, programs need to address the gender norms and relations that influence women's and men's ability to gain access to and act on the information and services that promote healthy relationships and successful family planning.

### KEY POINTS

**Traditional gender norms of femininity may limit women's access to information as well as their ability to control how and when they should engage in sexual relations.** Many traditional cultures expect women to be innocent, subservient, and modest. Norms that equate female sexual knowledge with promiscuity also affect women's ability to talk openly with health providers about intimate sexual issues. Both married and unmarried women who visit clinics for contraceptives may be stigmatized as promiscuous or "too independent," creating a social and psychological barrier that prevents them from making their own reproductive choices. In some traditional cultures, a woman's status is defined and a husband's virility is confirmed by her fertility. Cultural beliefs that place such importance on procreation affect a woman's ability to use or request that her husband use contraception.

Many cultures' prevailing myths and misconceptions about the use of modern contraceptives put psychological pressure on women who want contraception. Many of the myths imply that use of modern contraceptives may make women and men sterile and cause sexual dysfunction and deformities in a woman's children. To help women and their partners make informed choices about the method best suited to them, the myths and misconceptions need to be addressed in their gender and cultural context.

**Traditional norms of masculinity may limit a man's or his partner's use of family planning services.** It has always been assumed that men are indifferent or even opposed to family planning programs, but men also face stigma and discrimination that arise from preconstructed "masculine" gender roles. Male partners often face negative reactions from other men and family members when they attempt to become involved in women's or children's health. Many men also believe sexual myths about family planning, for example, that a vasectomy will affect their ability to function sexually, when in fact a vasectomy is safe, has few side effects, and has a low annual pregnancy rate of less than 1 percent.

**Power inequalities in relationships between men and women, especially related to control of decisionmaking power, economic resources, time, and mobility, also affect women's access to services and their ability to use family planning.** Men play an important role in regulating women's access to healthcare. A woman's perception of her husband's attitude toward family planning may strongly influence whether she uses contraception. In addition, as a consequence of the gender and community norms discussed above, women may also have limited personal and financial resources and mobility within their communities. These barriers may significantly hinder a woman from leaving the household and accessing family planning services.

**Many women may be afraid to raise the issue of contraception for fear that their partners may respond violently.** In some cultures, husbands may react negatively to family planning programs because they feel that protection against pregnancy will encourage their wives to be unfaithful.

**Women's decisions about family planning may also reflect pressures from family members to use a particular method or not to use any method.** When women have little autonomy, their husbands, mothers-in-



law, or other family members often make family planning decisions for them.

**Family planning clinicians have historically assumed an authoritarian role and expect the client to be passive.** Providers' failure to demonstrate psychosocial support and gender sensitivity may inhibit women from obtaining correct information about risks, benefits, side effects, and correct use, which is crucial to ensuring the initiation or continuation of family planning.

## STRATEGIES

The following strategies can help overcome gender-based obstacles to family planning:

- Increasing access to family planning and reproductive health information through existing reproductive health networks to reduce gender-related barriers to family planning. Reaching adults and young people where they are most active and through information channels familiar to them will improve a message's visibility and perceived normalcy. For young or recently married couples, who have limited knowledge about their reproductive health, programs can focus on couples-based counseling delivered by trained male/female health workers both at clinics and within the community in order to promote family planning and encourage partners to work together in making healthy decisions for themselves and their families. In most societies, a woman-to-woman approach is the best way to communicate with women about family planning and to offer services. By employing women, family planning programs also provide many women with new roles and opportunities in society. Peer education programs can also target adolescent boys and girls in school in combination with information campaigns delivered at places where men and women tend to congregate.
- Reaching women through community-based distribution (CBD) strategies to overcome practical obstacles imposed by gender inequality. CBD strategies overcome barriers such as restrictions on women's movement in public, access to money, and decisionmaking power without confronting the issue of inequality. CBD programs bring contraceptives to women in their homes, greatly reducing the social and economic costs of family planning. In addition, the programs have provided a source of employment and substantial social and material rewards to distributors.
- Involving men as partners to improve a couple's access to family planning information and services. While a woman can control her fertility without a man's cooperation, men's understanding and help can make contraception and family planning decisions easier and widen the choice of methods that a couple may use. In addition, to prevent sexually transmitted infection, a woman needs the cooperation of her male sexual partner, who must remain faithful to her or use condoms. Programs can adopt strategies that either challenge or accommodate men's "gate-keeping" authority. In addition, policy-level support is needed to encourage the expansion of programs for men as partners in reproductive health and family planning.
- Ensuring long-term sustainability through family planning programs that include strategies for redefining gender norms and encouraging healthy sexuality. Program strategies that promote the transformation of community norms include encouraging critical awareness of gender norms, challenging the imbalance of power between men and women, distributing resources and allocating duties between men and women, and addressing unequal power relationships between women and service providers. It is critical to deliver programs that strengthen women's autonomy and assertiveness in relationships with their partners and healthcare providers and build related future-oriented thinking, problem-solving, and decisionmaking skills. It is also critical to support programs that help men reassess their gender role and consider the benefits to themselves as well as to their partners of adopting more gender-equitable norms.
- Promoting male methods of family planning, specifically vasectomy to relieve women of some of the burden of family planning. Globally, 45 million couples rely on a vasectomy as a family planning method compared with 150 million couples who use female sterilization as their method of choice despite the fact that male sterilization is easier and safer. Vasectomy services can be successfully promoted through mass media campaigns, word of mouth, and the involvement of wives. In addition, separate clinics or waiting rooms and gender-sensitive providers may encourage use.
- Increasing provider awareness about the gender-specific norms and barriers that prohibit men and women from accessing and using family planning services in order to provide high-quality family planning services.

Successful methods of introducing family planning options to men in a gender-appropriate manner involve strategies such as condom social marketing, ensuring the availability of vasectomy services, delivering workplace programs, and operating male clinics that offer counseling services. Women should be provided with proper information regarding contraceptive choices, contraceptive negotiation skills, a comfortable environment where they feel free to discuss sexual issues, and male/female provider options. Providers seeking to enhance such programs and improve gender sensitivity should also encourage men and women to take more responsibility for their sexual behavior, help men communicate with their partners about contraceptive choices, and address the reproductive healthcare needs of the couple.

- Ensuring access to front-line reproductive health and family planning healthcare professionals to treat women who survive physical, sexual, and mental abuse. Gender-based violence (GBV) is increasingly recognized as a public health problem and a violation of human rights. Furthermore, reproductive health providers and family planning providers are often the only healthcare providers many women see. Yet, most reproductive health and family planning programs are not equipped to handle GBV issues. Program strategies that support healthcare workers and clinic workers in developing culturally appropriate methods to address GBV can help confront a key barrier to effective family planning as well as address women's fundamental human rights. Community advocacy strategies that recast gender norms such that GBV is socially unacceptable are also crucial to confronting GBV.
- Advocating vigorously for women-centered policies to help women meet their full potential. Policies that support the social acceptance of nonchildbearing roles of women can help women become economically independent and meet their family planning and fertility goals. Furthermore, women who can provide for themselves and their children can better protect themselves from coerced sex and unintended pregnancy. Changes that support options for women include an end to policies that encourage parents to favor sons over daughters, the elimination of arranged marriages of young girls, and the enactment and enforcement of minimum marriage ages.

## ILLUSTRATIONS

### AUTO DIAGNOSIS THROUGH THE REPROSALUD PROJECT

The reproductive health status of Peruvian women is among the lowest in Latin America. High rates of unintended pregnancies and births, complications from abortion, high-risk pregnancies and births, and high rates of STIs and reproductive tract infections (RTIs) place women at high risk of death and disability. Research in Peru has documented sociocultural barriers that distance communities from formal health services as well as gender barriers in the home and community that undermine reproductive health. Client-provider relations reflect mistrust between communities and reproductive healthcare, misunderstanding and disrespect for clients' cultural beliefs, and a lack of gender sensitivity in client-provider interactions. The gap created by gender, ethnic, and class differences and exacerbated by geographic and infrastructure barriers isolates many indigenous and poor communities in Peru and prevents many women from using family planning services. Those who do use services are often not assertive and may not use the services effectively. Due to the lack of control that many women have over factors that influence their health and healthcare, women receiving services often ask that their husbands receive reproductive health education as well. In some cases, women's groups have succeeded in establishing relationships with local health authorities. The groups have signed *convenios* (agreements) in which the health service agrees to respond to women's priorities and acknowledge their rights as clients while the women agree to support public health services and take action to increase utilization of the facility by others in their community.

The USAID-supported ReproSalud Project implemented by Movimiento Manuela Ramos conducts community-based workshops with women to identify, analyze, and prioritize reproductive health problems and develop solutions through participatory techniques such as sociodramas, story telling, and "problem trees." The most common reproductive health problems identified by women include too many children, suffering during childbirth, domestic violence, and "white menses" (vaginal discharge). Problem trees involve discussing a problem (the tree's trunk), its consequences (the branches and leaves), and its causes (the roots). This analytic exercise

helps develop project activities to address the root causes of reproductive health problems in the community. Initiated in nine provinces (predominantly low-literacy, rural mountainous areas), the program has reached 123,000 women and 66,000 men. The first cycle of project activities included reproductive health education to address selected problems. As a result of the exercises and interventions, men's and women's reproductive health knowledge improved for 14 out of 15 indicators of reproductive knowledge and practices (Boender et al., 2004; Ferrando et al., 2002). At the midpoint of the program, communities working with the ReproSalud Project showed significant progress over communities without project interventions, including increases in contraceptive use, knowledge of how at least one contraceptive method works, and attendance at a family planning/reproductive health facility (see Table 4).

#### IMPROVING VASECTOMY SERVICES IN SANTA BARBARA D'OESTE, BRAZIL

In 1994, the Center for Research on Maternal and Child Health in Brazil developed and implemented a vasectomy program to improve quality of care, reproductive choice, and client access to public health services. The center conducted a baseline survey and found that both men and women in Santa Barbara d'Oeste wanted greater access to family planning and reproductive healthcare. Men specifically mentioned that they wanted an increased focus on their reproductive health needs and wanted to be a part of the contraceptive decisionmaking process.

The project started by inviting women and their partners to attend a reproductive health consultation, encouraging men to participate in seminars on contraception and STIs. At the same time, municipal health facilities began to distribute condoms to men. The second phase of the project involved the organization of vasectomy services, which began with meetings with the municipal Secretary of Health to build political support. An existing health facility served as the pilot site. Providers were trained in performing vasectomies, high-quality family planning services, counseling and communication skills, contraceptive methods, sexuality, gender issues, and STIs and HIV/AIDS. The facility was also equipped with five vasectomy surgical kits.

In three years (1996–1999), 888 men requested vasectomies, of whom 535 met the eligibility criteria, underwent the procedure, and completed follow-up. Eleven men did not achieve azoospermia (the absence of sperm in the ejaculate) and underwent the procedure a second time. Four pregnancies occurred after vasectomy. An assessment of the program demonstrated the following conclusions:

1. It is possible to introduce reproductive healthcare for men in a small city in Brazil.
2. Program success was a function of quality of care and reproductive choice.
3. Vasectomy and other reproductive healthcare for men can be incorporated into women's care.

**Table 4. Reproductive Health Results—Midpoint of ReproSalud Project**

Women	INTERVENTION SITES (percent)		CONTROL SITES (percent)	
	Baseline (N=2132)	Midpoint (N=1852)	Baseline (N=1967)	Midpoint (N=1598)
In union using contraception	58.4*	71.8*	60.6*	64.6*
In union who know how at least one method works	13.5*	55.5*	14.9*	31.9*
Who attend a health facility for family planning/reproductive health services	26.3*	42.2*	22.5*	39.7*

\* p<0.05

Source: Ferrando et al., 2002

4. Promoting community and political support contributed to the project's sustainability.
5. Men who had undergone vasectomies played a major role in positive promotion of male sterilization and increasing male involvement in reproductive health.

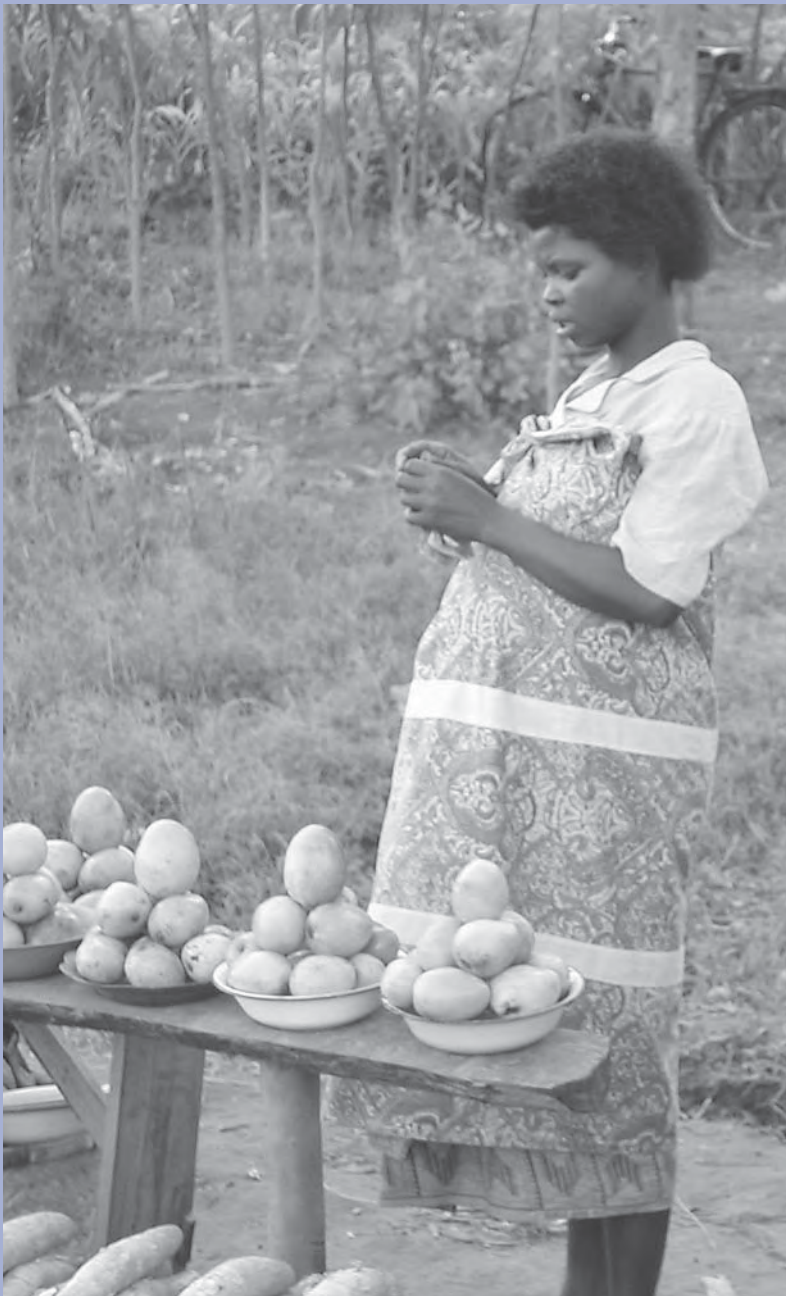
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## CHAPTER 5

# ADOLESCENT REPRODUCTIVE HEALTH



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Two issues are of the highest importance for adolescent reproductive health. The first is ensuring that young people have access to and are comfortable using reproductive healthcare. The second is to delay the age of marriage and first pregnancy to after the age of 20 to reduce the risk of maternal mortality and morbidity. Both these issues are addressed in this chapter.



## SECTION ONE YOUTH-FRIENDLY SERVICES

### ISSUE

With decreasing age of menarche and age at marriage, the risk of a young person experiencing an unintended pregnancy is greater than ever. Young people have the highest levels of unmet need for contraception; in fact, many sexually active young people will not use the public sector's reproductive healthcare services due to multiple cultural and socioeconomic factors. Those concerned about young people's exposure to unintended pregnancy and STIs/HIV have struggled to make these services more accessible to young people.

### KEY POINTS

**Developmentally appropriate messages and services must be designed for young people.** Youth who are not yet sexually active should receive information about abstinence and sexual delay. They should also receive education about fertility, pregnancy and reproductive health risks, and future contraceptive use as well as self-protection skills. Sexually active youth should receive information and services related to sexual delay, fertility, pregnancy and reproductive health risks, and contraceptive services. Sexually active married youth should be educated with messages about delaying a first pregnancy, child spacing, and contraceptive services (Family Health International, 2003).

**Youth seeking reproductive healthcare, especially unmarried girls, are often subject to judgmental attitudes on the part of service providers.** Some countries require parental permission for young people to access family planning and other health services. Some service delivery establishments do not operate at hours that are convenient for young people who are in school.

### STRATEGIES

Policy actions that would generally improve contraceptive availability to women and men also apply to young people. In addition, countries should undertake the following policy actions that are especially important in improving access for young people:

- Promoting abstinence while recognizing the contraceptive needs of sexually active youth. While abstinence is a primary means of preventing unintended pregnancy, policy should acknowledge that sexually active youth need access to contraceptive options.
- Ensuring that youth have access to a wide range of contraception. Most contraceptive methods are appropriate for adolescents. Legal, policy, and clinical guidelines should reflect international consensus on the safety and appropriateness of contraceptive methods so that health workers have clear guidance to advise and prescribe appropriately to young people based on sound medical criteria.
- Eliminating healthcare restrictions based on both social status (e.g., denying contraceptives to unmarried adolescents) or unfounded medical criteria.
- Ensuring that young people have access to comprehensive and accurate information about contraceptive options through schools and other relevant channels including community and faith-based organizations.
- Promoting dual protection against unintended pregnancy and STIs, including HIV.
- Supporting youth-friendly services that train health workers to address the special concerns of young people, that maintain confidentiality and privacy, and that are accessible and affordable to young people.



Good planning is essential to providing successful youth-friendly services. Achieving a national consensus for action is an important step toward planning and implementing a youth-friendly health services strategy. A policy initiative to raise the profile of adolescent health services identifies the departments and individuals critical to initiating the change process and sets up structures through which change can occur. Political support is important to start the process and to ensure that all government departments collaborate, bearing in mind that health and development needs cannot be met by health services alone. Political backing is critical for winning community support and developing a national sense of urgency. Additional strategic steps include:

- Learning about the health status of adolescents and their healthcare-seeking behavior.
- Developing a strategy to decide what youth-accessible services will be delivered, where, and by whom.
- Identifying an essential services package, core values, quality standards, and a process for quality improvement.
- Linking youth-accessible services with other services for young people.
- Involving youth in the design and implementation of services.
- Garnering community support to ensure that services are acceptable and used.

## ILLUSTRATIONS

Between 1998 and 2003, EngenderHealth and the International Center for Research on Women (ICRW), in collaboration with Nepali partners, assessed the impact of the participatory process on youth reproductive healthcare in developing countries. The quasi-experimental study provided three interventions in the control sites (adolescent-friendly services, peer education and counseling, and teacher training) and eight interventions in the study sites (adolescent-friendly services, peer education and counseling, an information and education campaign, adult peer education, youth clubs, street theater on social norms, efforts to improve livelihood opportunities, and teacher education). An evaluation of the activity found that while the basic indicators of

youth reproductive healthcare showed only a marginal improvement, there were substantial positive changes in terms of the broader, more contextual factors that influence youth reproductive healthcare, as well as capacity building, empowerment, and sustainability. For example, the participatory approach was far more effective than the traditional approach in improving reproductive healthcare antecedents and outcomes especially relevant to the Nepali context, such as age at marriage, initiation of childbearing, prenatal care, institutional delivery, and increased male awareness of the reproductive healthcare needs of women. The participatory approach was also found to be more effective than the traditional approach in improving basic reproductive health outcomes; however, it was not consistently more effective. This study demonstrates that when interventions aimed at youth development or social norms and systems are implemented using a participatory process, there is the potential for community buy-in and sustainable results at a minimal cost. These interventions are highly cost-effective because they allow for effective mobilization of local resources and initiative (Mathur, Mehta, and Malhotra, 2004).

International Planned Parenthood Federation/Western Hemisphere Region worked with its member associations in Latin America and the Caribbean to promote youth-friendly services (IPPF/WHR, 2005). As part of a small grants program, member associations across the region implemented a variety of activities such as making clinic spaces more youth-friendly, creating youth-friendly educational materials, sensitizing and training staff, and making services more affordable. The success of the grant activities showed that small investments can produce large impacts on youth-friendly services, that youth participation is essential to the success of any project, and that project monitoring through youth feedback can improve services and stay abreast of youth needs. For example, the Honduras affiliate used results from a focus group discussion with youth to create a friendly environment by redecorating its youth clinic. The waiting room now includes a suggestion box for client feedback so staff can improve its youth-friendly services. The affiliate in Paraguay redecorated one of its rooms in a clinic specifically for the use of young clients. The room included a small library, a television with educational videos, and consultation rooms. Youth volunteers helped paint a mural in the waiting room.

## RESOURCES

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## SECTION TWO

# MATERNAL MORTALITY DUE TO YOUNG AGE AT FIRST BIRTH

### ISSUE

Births to young women age 15 to 19 represent about 11 percent of all births in developing countries (15 million births annually to women ages 15–19). Many of these 15 million young mothers have given birth before their bodies have fully matured, placing them at great risk of complications during pregnancy and delivery and subsequent maternal death and disability (YouthNet, 2004a). In sub-Saharan Africa, more than half of women give birth before they reach 20 years old, and in Latin America one-third of women give birth in their teenage years. Worldwide, women 15 to 19 years old are twice as likely to die during childbirth than women in their 20s, and girls 14 years old and younger are more than five times as likely to die during childbirth than their counterparts in their 20s (YouthNet, 2004b).

### KEY POINTS

**Young mothers are at increased risk of pregnancy and delivery complications.** Because their bodies are not fully matured, young women are more likely than older women to experience vaginal tears, obstructed labor, fistula, excessive bleeding, and infection during and after childbirth. Given their physical limitations, young mothers may require emergency obstetric care, including cesarean section and assisted vaginal delivery. The availability of skilled pregnancy care, attendance at delivery, and postpartum care is especially important at first births because women may be less aware of signs of pregnancy complications and are more likely to experience labor complications.

Obstetric fistula is an especially devastating condition disproportionately affecting young women. The condition affects between 50,000 and 100,000 women each year, most often the young and poor (EngenderHealth and UNFPA, no date). A result of extended obstructed labor, fistula often results in the death of the child and tissue damage, infection, and incontinence for the mother. Early pregnancies are the most common cause of obstructed

labor and hence fistula. Depending on nutritional levels and individual and population variations, a woman's skeletal system continues to grow until approximately the age of 18, and her birth canal remains immature until approximately age 20 to 21. These developmental conditions could increase her physical risk of obstructed labor. Access to emergency obstetric services and delay in first marriage and pregnancy until a woman's body is mature enough for motherhood could prevent obstetric fistula and its physical and emotional suffering.

Young mothers are also at higher risk of preterm birth and delivering low-birthweight babies. Women in their first pregnancy are more susceptible to ill health from malaria, and pregnant adolescents are more likely to suffer from nutritional iron deficiency, situations that increase the risk of preterm or low-birthweight babies.

**Adding to these complications, infants born to young mothers are more likely to suffer and die from disease than those born to older women.** The increased risks of preterm and low-birthweight babies place the infants of young mothers at greater risk of illness and death. Many adolescents do not seek antenatal, delivery, and postpartum care, placing themselves and their babies in danger of dying from preventable and treatable causes.

### STRATEGIES<sup>10</sup>

General policies applicable to mothers of all ages should aim to improve access to basic maternity care, including safe delivery and pre- and postnatal care. Policies specific to young people should include:

- Recognizing the age-specific medical problems affecting young women. Policies should acknowledge that the treatment and management of adolescent mothers differs in important ways from that of adult women.

10. All strategies are taken from the youth-policy.com "Maternity Care and Safe Delivery Fact Sheet."

- Promoting laws and policies that reduce pregnancy-related death and illness. Laws should promote young women's access to reproductive healthcare and information and protect young women's health by, for example, prohibiting early marriage.
- Acknowledging the need for youth-focused information, education, and communication (IEC) campaigns. Education campaigns should provide appropriate, comprehensive, and accurate information on reproduction; the danger and consequences of early pregnancy; contraception; decisionmaking skills; gender relations; and the positive aspects of delayed marriage/sexual activity, education, and economic empowerment.
- Addressing the underlying causes of pregnancy-related health problems in youth by, for example, promoting family planning services to prevent early pregnancy, emphasizing expanded educational opportunities for girls, addressing problems of poverty and malnutrition, and promoting community education to encourage families and individuals to delay marriage and first births.
- Addressing education and other policies that prevent expulsion of pregnant girls from school.

## ILLUSTRATIONS

Despite their increased risk of maternal death and disabilities, adolescents are less likely than their older counterparts to use reproductive health and maternal health services. A 2004 YouthNet publication titled "Maternal Health Care among Adolescents" summarizes research findings over the last 15 years on adolescent use of health services. The publication, which describes a 2003 study of DHS data in Bangladesh, Brazil, Cambodia, India, Indonesia, Nepal, and Peru, found that youth under age 19 were less likely to use prenatal and delivery care than older women in Bangladesh, Brazil, India, and Indonesia. An earlier study of DHS data from 1985 to 1990 found that young women under age 18 were less likely than women age 18 to 34 to seek prenatal care services in 18 of 26 countries studied and less likely to use skilled delivery services in 16 of 28 countries. A 1990 study found that mothers under age 20 were less likely than those in their 20s to use maternal and child health services.

Save the Children's 2004 annual "State of the World's Mothers" report focused on adolescent pregnancy, outlining the maternal and child risks of young pregnancies and identifying 50 countries where the risks are greatest. According to the report, babies born to teen mothers have a 50 percent greater chance of dying before their first birthday than babies born to mothers in their 20s. Each year, 70,000 girls and one million infants born to young mothers die due to complications from pregnancy and childbirth. Within the 50 most problematic countries, one-quarter of girls age 15 to 19 are married, 10 percent of young women in the same age cohort give birth in a given year, and 11 percent of babies born to these young mothers will not live beyond one year.

The Save the Children report goes on to note that young mothers are more likely to suffer from pregnancy and delivery complications and give birth to small and premature children who are more susceptible to illness and death. Girls in developing countries are likely to be married to or engage in sex with older men, putting themselves at greater risk of HIV/AIDS and placing their children at risk of vertical transmission of the virus.

According to the report's Early Motherhood Risk Ranking, which analyzed early marriage rates, adolescent birth rates, and infant mortality of children born to mothers under age 20, Niger, Liberia, Mali, Chad, and Afghanistan are the top five of 50 countries where the lives of adolescent women and their children are at risk.

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## CHAPTER 6

# COUNTRY-LEVEL ADVOCACY STRATEGY FOR REPOSITIONING FAMILY PLANNING/REPRODUCTIVE HEALTH



TRAN THI HOA/THE WORLD BANK

Effective advocacy campaigns to promote family planning are based on well-thought out advocacy strategies that direct the advocacy work toward pre-determined objectives and goals. This chapter outlines the steps in designing a strategy for a family planning advocacy campaign.

## SECTION ONE ADVOCACY STRATEGY

### ISSUE

In the developing world, family planning has slipped from the forefront of health issues in many countries. The slippage has contributed to severe funding gaps and a lack of information and political will around family planning issues, thus limiting the ability of countries to provide their citizens with high-quality reproductive health and family planning services. This chapter provides a framework for those wishing to work toward the repositioning of family planning and/or reproductive health in their respective countries. The approach detailed in this section is based on *Networking for Policy Change: An Advocacy Training Manual*, developed by the POLICY Project (1999).

### KEY POINTS

The advocacy strategy presented here is intended to be adapted to conditions on the ground—to the environment where the campaign to reposition family planning is taking place. Implementers should choose activities that address needs or gaps in their country. In addition, although the strategy development process is presented in steps, it is likely that some steps will overlap rather than follow a linear progression.

### STRATEGY

#### STEP 1. FORM A WORKING GROUP

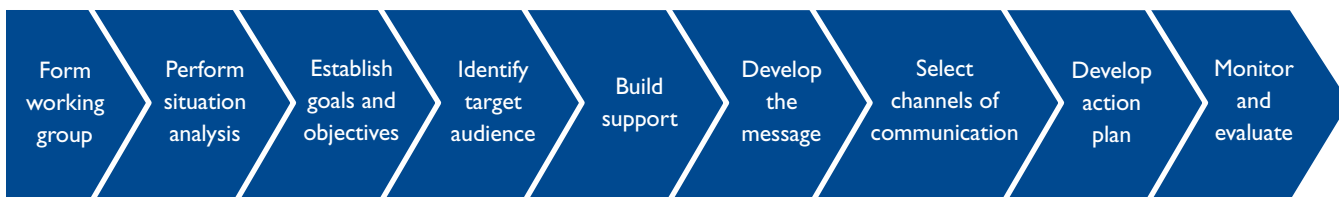
The working group will provide the backbone of the campaign to reposition family planning and reproductive health services. Its membership should be as diverse as possible and include representation from the public and private sectors as well as from relevant NGOs, civil society groups, and individuals.

#### STEP 2. PERFORM A COMPREHENSIVE SITUATION ANALYSIS

A situation analysis guides the campaign in directly targeting any barriers to providing more complete family planning services as determined by a country's unique environment while providing the building blocks of an effective evidence-based advocacy campaign. The analysis should address the following as well as any other topics of interest to a given country:

- The current situation, including levels of indicators of interest such as unmet need, HIV prevalence, contraceptive prevalence rate, desired and actual fertility rates, and maternal mortality ratio.

**Figure 2. Developing a Strategy for Repositioning Family Planning**



- Impact of country performance of above indicators on long-term economic growth and socioeconomic development.
- The number of trained and skilled providers in both rural and urban clinics.
- Levels and trends of population demographic indicators, including age-specific population cohorts as well as future demand for family planning and reproductive healthcare services.
- Social structure.
- Factors influencing decisionmakers' reprioritization of family planning (including other needs, such as HIV).
- Identification of decisionmakers with power over budget allocations and determination of their attitudes and knowledge levels with regard to family planning and reproductive health.
- The current family planning and reproductive healthcare advocacy strategy.
- Identification of stakeholders.
- Analysis of gender norms, roles, and inequalities.
- Roles of the public, private, and NGO sectors in family planning and reproductive healthcare.
- Analysis of the policy environment.

### **STEP 3. ESTABLISH A CLEAR GOAL, OBJECTIVES, AND PERFORMANCE INDICATORS**

Establishing a clear goal, objectives, and performance indicators to measure progress is essential to a campaign's success. Although the overarching goal of the campaign is to improve access to and provision of family planning and reproductive healthcare and products, any goal involves a number of components. In the short term, the campaign should focus on achieving those narrower components.

A goal is a broad statement of what the group hopes to achieve over the next three to five years. The objectives describe what the group hopes to accomplish in the short term and allow the group to narrow its focus to determine

how to reposition family planning and reproductive healthcare in the given country (see Box 1).

#### **Box 1. Sample Objectives**

An advocacy strategy in Kenya has set forth the following objectives:

- Strengthen political commitment to reproductive health programming;
- Achieve stronger and more visible reproductive health/HIV integration at both policy and service delivery levels; and
- Increase public uptake of reproductive healthcare by implementing strategies and activities that increase those desiring contraception.

Fulfilling the above objectives will allow policymakers to work toward their plan to:

- Ensure that at least 60 percent of six selected districts have a three-month contraceptive commodities buffer stock; and
- Increase family planning uptake by 5 percent in selected facilities within the six districts.

Source: Aloo-Obunga, n.d.

Objectives should be

- Specific
- Measurable
- Achievable
- Realistic
- Time-bound

In many cases, objectives cluster around (1) changes in funding practices and levels, (2) changes in the policy environment for family planning and reproductive health, and/or (3) changes in logistical support for family planning and reproductive health.

After identifying its objectives, the group should determine how to measure progress toward those objectives. Indicators that measure progress should be

selected and monitored as part of the ongoing campaign. Indicators should be clear, easily measurable, and reliable (see Box 2).

#### **Box 2. Sample Performance Indicators**

- Total fertility rate
- Unmet need for contraceptives
- Stockout rates for contraceptives
- Contraceptive prevalence rate

#### **STEP 4. IDENTIFY THE TARGET AUDIENCE**

The target audience can be broadly or narrowly defined. It is important to link the definition of target audience to the findings from the situation analysis. For example, the target audience can be policymakers with decisionmaking power over family planning and reproductive health funding. The audience could also be highly visible opinion leaders or a broader category of actors such as potential family planning consumers. This is not an exhaustive list; members of the working group should brainstorm the variety of potential target audiences within their country. The primary criterion for determining the target audience should be the audience's ability to influence funding decisions, the policy environment, and logistical support for family planning and reproductive health.

#### **STEP 5. BUILD SUPPORT AND STRENGTHEN RELATIONSHIPS**

By building support and strengthening relationships, the advocacy activity will gain momentum and sustainability.

- Build support for the campaign so that the group will be able to draw on the strengths of a broader base.
- Use networking tactics. Groups of organizations and individuals are often more powerful than individuals working alone. The network should put in place mechanisms for specifying a clear organizational structure, determining meeting times, and informing members of relevant news.
- Strengthen civil society partnerships.
- Reinforce relationships between the Ministry of Health and other government entities responsible for matters related to population, reproductive health, and social welfare.

- Compile comprehensive contact information for all potential partners and current group members.

#### **STEP 6. DEVELOP THE MESSAGE**

The message is what will be communicated to the target audience. Different audiences, with different concerns and education levels, require different messages or presentations. A message crafted to speak directly to the target audience's concerns or information gaps will prove most effective. This family planning advocacy toolkit can provide a basic framework for developing relevant messages for the country-level advocacy strategy.

Information is crucial to creating an effective message. Data analysis and presentation tools and models can help build a compelling, evidence-based campaign. For more information on these tools, please see Chapter 7. Choosing the appropriate approach will strengthen the message. It is essential to select the model that will generate information most directly relevant to the issues addressed in the campaign.

It is also important to provide a feasible solution to the problems. When presented with a solution along with the problem, decisionmakers are more likely to solve the problem. (Please refer to Chapters 1–5 for examples of topical messages and strategies for family planning.)

#### **STEP 7. SELECT CHANNELS OF COMMUNICATION**

With the definition of the target audience and identification of the message to be conveyed to the audience, the next step is to determine how to deliver the message. The channels of communication should reinforce the importance of the message and its validity and provide an opportunity for recipients to consider the message's content. The selection of communication channels should also take into consideration the target audience's habits and activities, with information conveyed in ways most likely to reach and hold the target audience's attention. Some of the most common channels of communication include the following:

- Fact sheets
- Press kits and releases
- A conference for policymakers
- Meetings with decisionmakers

- A briefing book with information regarding population, reproductive health, and development issues
- Goodwill ambassadors
- Briefings for ministries and secretariats
- Training for advocates at the community and regional levels

#### STEP 8. DEVELOP A PLAN OF ACTION

A detailed workplan should outline each activity required to meet the objectives of the group (see Box 3) and specify the following:

- The person or organization responsible for the activity.
- The time frame within which the activity should be completed.
- Any support required to complete the activity.
- Those accountable for the agreed-upon tasks.

#### Box 3. Examples of Actions From Other Repositioning Family Planning and Reproductive Health Campaigns

- Brief parliamentarians on importance of family planning
- Mobilize the community via advocacy training
- Identify and establish relationships with family planning/reproductive health champions
- Write and disseminate a "Population, Reproductive Health, and Development" briefing book
- Facilitate joint planning meetings between budgetary authorities and the family planning secretariat
- Train advocates for family planning and provide them with evidence for their activities
- Form a national umbrella organization to unify family planning advocacy groups
- Disseminate data to stakeholders
- Organize special events with goodwill ambassadors
- Conduct sensitization meeting for social welfare committee

#### STEP 9. MONITOR AND EVALUATE PROGRESS

At all points in the campaign, group members should monitor progress on the indicators selected in Step 3 in order to identify successes and rethink their strategy for actions that may not be as successful as hoped. The campaign should be flexible enough to evolve. Monitoring activities will identify activities that require change as well as successful strategies.

At the end of an activity, it is important to evaluate progress. Experience provides valuable lessons, and evaluation activities should be designed to capture these lessons. At this stage, best practices as well as not-so-successful techniques will become evident. In addition, any change on the indicators of interest should be recorded. The information resulting from the evaluation demonstrates program progress and can be used to seek resources or demonstrate success.

#### MOVING FORWARD

Even at the end of a successful advocacy campaign, gaps in family planning and reproductive health services will likely remain. The skills, information, and relationships gained during the campaign can be used to address these issues.

#### RESOURCES

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## CHAPTER 7

# MODELS, FRAMEWORKS, AND TOOLS



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Communicating correct information and relevant data and successful strategies is one of the most vital components of an effective advocacy campaign for improved family planning services and programs. It requires correct and poignant information presented as effectively as possible. The following models, frameworks, and tools can assist in the collection of information essential to communicating and developing an advocacy strategy.

## SECTION ONE MODELS

Through proper analysis and dissemination, the outputs of computer models can draw attention to priority action areas, identify the effects of various funding and implementation strategies, and function as an advocacy tool for NGOs and civil society groups.

**SPECTRUM** is a suite of models used to project the need for reproductive healthcare and the consequences of not addressing reproductive health needs. Included in the suite are DemProj, FamPlan, AIM, RAPID, Ben-Cost, NewGen, PMTCT, and Condom Requirements. Each model includes a detailed user manual that not only describes how to use the software but also provides sections on data sources, interpretation and use of the results, a tutorial, and a description of the methodology. SPECTRUM is available at <http://www.policyproject.com/software.cfm?page=Software&ID=Spectrum>.

**DemProj** is used to make population projections for policy presentations or other planning exercises and to create the population projections required by the other programs in SPECTRUM. It projects the population for an entire country or region by age and sex based on assumptions about fertility, mortality, and migration. A full set of demographic indicators can be displayed for up to 50 years into the future. Urban and rural projections can also be prepared. A companion model, EasyProj, supplies the data needed to make a population projection from the estimates produced by the Population Division of the United Nations. DemProj is available as part of SPECTRUM and can be accessed at <http://www.policyproject.com/software.cfm?page=Software&ID=Spectrum>.

The **FamPlan** Model projects family planning requirements needed to reach national goals related to addressing unmet need or achieving desired fertility. It can be used to set realistic goals and to plan for the service expansion and financial resources required to meet program objectives. The program uses assumptions

about the proximate determinants of fertility and the characteristics of the family planning program (method mix, source mix, discontinuation rates) to calculate the cost and number of users and acceptors of different methods by source. It can simulate various strategies as a way to evaluate alternative methods of achieving program goals, allowing users to address their goals more effectively with the resources available to them. FamPlan is available as part of SPECTRUM and can be accessed at <http://www.policyproject.com/software.cfm?page=Software&ID=Spectrum>.

**AIM** (AIDS Impact Model) projects the consequences of the HIV/AIDS epidemic, including the number of people living with HIV/AIDS, new infections, and AIDS deaths by age and sex as well as new cases of tuberculosis and AIDS orphans. UNAIDS uses AIM to make the national and regional estimates it releases every two years. AIM is available as part of SPECTRUM and can be accessed at <http://www.policyproject.com/software.cfm?page=Software&ID=Spectrum>.

The **Goals** Model is intended to support strategic planning at the national level by providing a tool to link program goals and funding. The model can help planners understand how funding levels and patterns can lead to reductions in HIV incidence and prevalence and improved coverage of treatment, care, and support programs. It does not, however, calculate the “optimum” allocation pattern or recommend a specific allocation of resources among prevention, care, and mitigation. Goals runs under Microsoft Excel and can be accessed at <http://www.futuresgroup.com/Resources.cfm?area=2a&get=GOALS>.

The **RAPID** Model projects the socioeconomic impacts of high fertility and rapid population growth. The projections are used in presentations to decisionmakers at all levels to encourage policy dialogue about the need for effective family planning and reproductive health

programs and to build essential support. The presentation is designed to illustrate the socioeconomic impacts of high fertility and rapid population growth and looks closely at demography, economy, education, health, urbanization, and agriculture. Decisionmakers can better grasp the implications, both financially and socially, of not taking action when presented with concrete figures. RAPID is available at <http://www.futuresgroup.com/WhatWeDo.cfm?page=Software&ID=Rapid>.

The **BenCost** (Benefit-Cost) Model compares the monetary cost of family planning programs with monetary benefits associated with reduced levels of social services required at lower levels of fertility. BenCost allows the user to study the long-term economic costs and benefits to society resulting from changes in family planning programs. Benefits are defined as savings in government expenses on social services. BenCost allows planners to add the cost of health, education, and other social services to population projections created with the DemProj and FamPlan modules. BenCost is available as part of SPECTRUM and can be accessed at <http://www.policyproject.com/software.cfm?page=Software&ID=Spectrum>.

**NewGen** projects the characteristics of the adolescent population in terms of indicators such as school enrollment, sexual activity, pregnancy rates, prevalence of HIV and STIs, and marriage rates. It permits an examination of the linkages among these indicators and the effects of policy changes. NewGen is available as part of SPECTRUM and can be accessed at <http://www.policyproject.com/software.cfm?page=Software&ID=Spectrum>.

**PMTCT** evaluates the costs and benefits of intervention programs to reduce transmission of HIV from mother to child. The model includes three sets of interventions: drug treatment (seven options), type of delivery (vaginal or cesarean section), and type of infant feeding (formula, breastfeeding, or mixed). Outputs include a benefit-cost ratio as well as cost-effectiveness measures such as cost per HIV infection averted. PMTCT is available as part of SPECTRUM and can be accessed at <http://www.policyproject.com/software.cfm?page=Software&ID=Spectrum>.

**Condom Requirements** is a program to forecast national condom requirements for both family planning and HIV/

AIDS prevention, focusing on the critical groups at risk in the population. Condom Requirements is available as part of SPECTRUM and can be accessed at <http://www.policyproject.com/software.cfm?page=Software&ID=Spectrum>.

The **Allocate** suite is a tool that allows policymakers to see which reproductive health goals are achievable and what resources are required to achieve them. It is intended to support priority-setting dialogue by supporting reproductive health action plans with increased efficiency in the use of funding resources and create a better dialogue between all stakeholders regarding reproductive health priorities. The following models are included in Allocate; DemProj, FamPlan, the Safe Motherhood Model, the Postabortion Care Model, and the Child Survival Model. Allocate is not yet available on the Web.

The **Safe Motherhood** Model represents the relationships between national maternal health programs and the resulting maternal mortality ratio and number of maternal deaths. The model helps determine which safe motherhood interventions, alone or in combination, help reduce the maternal mortality ratio. The model is based on the 2002 Maternal and Neonatal Program Effort Index (MNPI), a study of 59 countries that asked experts in each country to rate 81 features of their respective national maternal and child health programs. The model is one of several that make up the forthcoming Allocate suite developed by the POLICY Project. Allocate is not yet available on the Web.

The **Postabortion Care (PAC)** Model looks at the percent of abortions that are legal, percent of abortions that need treatment, percent of all maternal deaths due to abortions, and the relative risk of mortality for untreated versus treated abortions. With this information, the model can assess the impact of resources allocation decisions on the number of maternal deaths that are a consequence of abortions, including deaths due to legal and illegal abortions, whether the abortions receive or do not receive treatment. It can also examine the impact of resource allocation decisions on the total number of abortions in a specific year. The PAC Model is one of several that make up the forthcoming Allocate suite developed by the POLICY Project. Allocate is not yet available on the Web.

The **Child Survival** Model allows the user to explore the impact of resource allocation decisions on the infant

mortality rate, under-five mortality rate, and child deaths in a given country. The inputs required for this model are already provided by the various modules of SPECTRUM with the exception of the percent of births with any risk in the base year. This model is one of several that make up the forthcoming Allocate suite developed by the POLICY Project. Allocate is not yet available on the Web.

The **REDUCE** Model is a model used to advocate for decreasing maternal mortality, morbidity, and disability rates. Poor maternal health dramatically reduces women's capacity to grow out of poverty. REDUCE estimates the impact of maternal death on survival and productivity and translates the consequences of inaction into tangible economic loss figures that can be used to influence policy and decisionmakers.

The **ALIVE** Model concentrates on saving newborn lives by providing a framework in which advocates for better neonatal healthcare can discuss ways to increase the rate of newborn survival. The model highlights the economic and social benefits of improved neonatal healthcare. Actions recommended to reduce newborn mortality are relatively simple and include ensuring clean delivery and cord care, drying and wrapping the newborn immediately following delivery, and starting breastfeeding as soon as possible. Developed by the Academy for Educational Development (AED) in response to the success of its **REDUCE** Model, **ALIVE** can be used as an effective advocacy tool for increased spending on maternal health, family planning and birth-spacing programs, and policy change.

For more information on the REDUCE and ALIVE models, contact AED or visit its Website at [www.aed.org](http://www.aed.org).

## SECTION TWO FRAMEWORKS

### SITUATION ANALYSIS

Performing a situation analysis allows an advocacy campaign to address directly the challenges that are unique to a given country's environment in providing more complete family planning services. Analysis of the current situation provides the basis for an effective evidence-based advocacy campaign. Any situation analysis should answer the following questions (with additional questions included if necessary):

1. What is the situation on the ground? List indicators of interest and the country's performance on them. Identify vulnerable groups, and, if possible, break out their performance on the same indicators. Indicators might include desired fertility rate, actual fertility rate, unmet need, and maternal mortality ratio.
2. What are the potential long-term results of the indicators? For example, a rapid population growth rate could limit a government's ability to provide services to all citizens or limit other potential gains in socioeconomic development.
3. What indicator trends exist? What is the age distribution of the population and how does that distribution affect current and future needs? For example, what percent of the population is under age 15, and how will the size of the under-15 cohort affect access to family planning and reproductive health services in upcoming years?
4. What is the social and cultural context of family planning and reproductive health, and how might it affect the population's acceptance of services? For example, how do religious traditions and restrictions, gender roles, women's empowerment, family structure and hierarchy, marriage, and childbearing affect family planning and reproductive health?
5. What type of school-based reproductive health education is offered, if any?
6. What is the social structure and its related constituencies? For example, are societies organized into kingdoms or faith-based communities?
7. Who are the decisionmakers regarding the priority assigned to health issues? Do they have decisionmaking authority regarding budget allocations? What are their official and unofficial stances on family planning/reproductive health services? What is the bureaucratic structure within which the relevant decisionmakers function? What are the society's other respected institutions, such as academic institutions and/or medical professional groups?
8. Why have policymakers assigned lower priority to family planning? Did it ever attain higher priority? Is HIV/AIDS seen as a higher priority? Does some other health or social concern have higher priority? In other words, what is the "competition" for funds? What linkages exist between HIV/AIDS services and family planning/reproductive health services?
9. What types of family planning advocacy strategies are in place? What are their strengths and weaknesses?
10. Who are the stakeholders in the current environment? What are their positions, why do they care, what is their perspective on family planning and HIV/AIDS issues, what is their training (doctors, nurses, public health professionals, civil society groups, patients and potential patients)? What will be their role in the advocacy action campaign? For example, will they be advocates, the target of advocacy, opponents, or neutral observers?
11. What roles do the public, private, and NGO sectors play in the provision of family planning and reproductive health services? What entities in these sectors play a role in family planning and reproductive health? Are there any community mobilization organizations outside the family planning and

reproductive health area that might have an interest in a family planning advocacy campaign? Of the currently involved organizations, are there any particularly successful civil society groups, and which demonstrate the greatest potential? What would they need to be more successful?

12. What commitments did the country make at the 1994 ICPD? Is it fulfilling those commitments?
13. What is the policy environment for family planning and reproductive health? What are the formal commitments to family planning and reproductive health? Are they being met? How much of an understanding of family planning and reproductive health and its linkages with other social goals do policymakers (both local and national) demonstrate? What tools are in place for family planning and reproductive health advocacy? Who developed and uses them? Who is the audience? What obstacles does the policy environment pose, and how can they be minimized? Identify national or local policy documents relating to family planning, such as the Poverty Reduction Strategy or goals of the Ministry of Health.
14. How do the media portray family planning and reproductive health issues?

## **ADVOCACY ACTION PLANS**

Action plans guide a network through an advocacy campaign and should include a monitoring and evaluation plan. The action plan is presented in a simple format. Based on a selected advocacy objective, participants design specific activities for implementation in order to achieve the network's objective. Members of the network provide details describing the needed resources, responsible person(s), and an appropriate time frame for each activity. The action plan should be developed with input from and the consensus of the entire network membership in order to create a sense of shared ownership and commitment to the plan and strategy. A sample advocacy action plan follows.



## Sample Advocacy Action Plan

### Advocacy Objective:

**To achieve stronger and more visible family planning/HIV integration at both the policy and service delivery levels**

Activity	Needed Resources	Responsible Person(s)	Time Frame	Performance Measures (outputs)
Facilitate a stakeholders' meeting to discuss the importance of family planning/HIV integration at the political level	Meeting space; presentations; fact sheets for stakeholders	Working Group	2 weeks	Attendance list; a statement outlining the goals, objectives, and buy-in of stakeholders
Facilitate training of providers on the medical aspects of family planning and HIV	Training manual and other materials; training space; refreshments	Working Group, Ministry of Health	4 weeks	Attendance list; plans of action for participants
Conduct an IEC campaign to promote public awareness and educate the public on the facilities that offer family planning/HIV integrated services	IEC materials (brochures, posters, television and radio advertisements, and so forth); personnel to distribute and promote IEC materials	Ministry of Health, Working Group, NGOs; volunteers	6 months	Number of brochures and so forth distributed; frequency of television and radio advertisements
Assess utilization rates of facilities that offer integrated family planning/HIV services	Data collection tools; data analysis software and computers; data-entry and analysis personnel	Working Group, Ministry of Health	2 months	Report outlining the trends in service utilization rates

## Advocacy Action Plan (template)

### Advocacy Objective:

**To achieve stronger and more visible family planning/HIV integration at both the policy and service delivery levels**

Activity	Needed Resources	Responsible Person(s)	Time Frame	Performance Measures (outputs)

## SECTION THREE TOOLS

### TOOLS

The **Maternal and Neonatal Program Effort Index (MNPI)** is a standardized assessment instrument designed to measure the strength and character of government programs aimed at improving maternal and neonatal health. It contains items for the most proximate determinants of maternal and neonatal survival, including those related to emergency obstetric and abortion cases, as well as the less proximate determinants of the policies and institutional arrangements necessary to build treatment capacities. Capturing these program features can document the low effort levels that now exist and create a baseline against which to track future improvements. The overall purpose is to measure program inputs and strength of effort for the reduction of maternal mortality and morbidity and closely related neonatal interventions. For more information on the MNPI, visit <http://www.policyproject.com/pubs/mnpi.cfm>.

The **Family Planning Program Effort Index** captures program effort or strength, independent of outputs such as contraceptive use or fertility change. By focusing on 30 features of program effort, the relationship between effort and outcomes can be examined. The scores are also useful for diagnosing program weaknesses and detecting improvement over time. For more information on the program effort index, visit <http://www.futuresgroup.com/abstract.cfm/2886>.

The **Strategic Pathways to Reproductive Health Commodity Security (SPARHCS)** framework can be applied to take an inventory of the current family planning situation and accurately assess need, services, financing, policies, leadership, and product availability. The SPARHCS framework can reveal the barriers women face in the existing system in choosing, obtaining, and using contraception. Once issues are identified, countries can effectively address them in their contraceptive security plans and then overcome them. SPARHCS is a systematic, comprehensive, participatory process that is meant to

be applied and monitored by countries and their donor partners. Main areas of interest include human and organizational capacity, logistics, policy, service delivery, demand, finance, and private sector involvement. For more information on the SPARHCS framework, visit <http://www.usaid.gov>.

The **Networking for Policy Change: An Advocacy Training Manual** is an advocacy model as well as training methodology for advocacy training. It is based on the principle that advocacy strategies and methods can be learned by adults through a participatory process. It is organized around a well-developed model—tested over time and within diverse cultures—for achieving advocacy objectives. The manual includes a section on the building blocks of advocacy (the formation of networks, identification of political opportunities, and organization of campaigns) with specific subjects presented in individual units. While the manual can be used in its entirety, it is designed for use in sections depending on the needs of the network. The POLICY Project and the Centre for Development and Population Activities (CEDPA) jointly developed the document, which may be downloaded from <http://www.policyproject.com/pubs/AdvocacyManual.cfm>.

The **Networking for Policy Change: An Advocacy Training Manual: Contraceptive Security Supplement** builds upon the original document. It focuses on contraceptive security, the goal of which is to ensure that every person is able to choose, obtain, and use high-quality contraceptives whenever s/he needs them. This supplement is intended for use in contraceptive security advocacy training for two types of audiences. The first involves the same audiences as in the original advocacy manual—primarily nongovernment networks and coalitions advocating for family planning and reproductive health as well as multisectoral alliances or NGOs and national/local government agencies or representatives. The second type of audience is contraceptive security

committees or task forces. Such committees are formed in countries where SPARHCS—Strategic Pathways to Reproductive Health Commodity Security—is being used (see above for more detail on SPARHCS). This supplement is not yet available online.

The **Networking for Policy Change: An Advocacy Training Manual: Maternal Health Supplement** is a resource for trainers involved in family planning and reproductive health advocacy issues worldwide. As with any advocacy effort, special concerns must be addressed when talking about advocacy for maternal health. The supplement provides specific information relating to maternal health that goes beyond the examples and materials included in the original manual. The Maternal Health Supplement is not intended for use only by advocacy networks concerned exclusively with maternal health issues but also serves networks that advocate for family planning and reproductive health issues and that have identified maternal health as their primary focus. The POLICY Project and CEDPA jointly developed the document, which can be downloaded from [http://www.policyproject.com/pubs/manuals/MH\\_FULL.pdf](http://www.policyproject.com/pubs/manuals/MH_FULL.pdf).

The **What Works: A Policy and Program Guide to Evidence on Family Planning, Safe Motherhood, and STI/HIV/AIDS Interventions** series provides a list of reproductive healthcare interventions and the supporting research that documents the effectiveness of such interventions. The guide will be helpful to those developing guidelines for best practices. It summarizes research published in peer-reviewed publications by providing clear and transparent data on the effectiveness of various reproductive health interventions, programs, and policy initiatives that can be implemented to improve family planning/reproductive health and reduce STI/HIV/AIDS in developing countries. Biomedical information is included in so far as it is relevant to program considerations. The document may be downloaded from [http://www.policyproject.com/pubs/generalreport/SM\\_WhatWorksps2.pdf](http://www.policyproject.com/pubs/generalreport/SM_WhatWorksps2.pdf).

The **Policy Circle** is a framework for understanding and influencing the policy process. In conjunction with the information presented in this toolkit, the Policy Circle can help advocates, members of civil society, and those formally involved in the policy process identify the most appropriate opportunities for involvement in the policy process and the most effective arguments for such

involvement. The information presented in this toolkit can be used as an essential input into the process at any one of the stages identified in the Policy Circle.

The Policy Circle framework demonstrates the several points in the policy process that lend themselves to influence. Given that the user may decide to become involved at different points in the policy process—and therefore will need substantially different information and approaches—this guide offers a variety of approaches to be followed at several points during the process. For example, if the user is addressing an audience concerned with economic issues and stresses the macroeconomic benefits of family planning programs, the user might use the information in Chapter 2 for application to appropriate points on the Policy Circle.

Demographic statistics can be used as technical evidence during the *Problem* stage to demonstrate the extent of unmet need or growing need for family planning. A cost-benefit approach may be applied for the *Price Tag* component or for resource allocation during the *Paper* stage. And the *People/Places* component of the Policy Circle may offer an opportunity to examine the demographic group and associated stakeholders most affected by a new policy.

The policy process is fluid and dynamic; components of the process affect one another as well as the process as a whole. Strategically influencing the process at all points on the Policy Circle increases the chances that the final policy will reflect stakeholders' priorities and principles. The document may be downloaded from <http://www.policyproject.com/pubs/workingpapers/wps-11.pdf>.

**Promises to Keep: The Toll of Unintended Pregnancies on Women's Lives in the Developing World**, by the Global Health Council, is a compilation of statistical analyses designed to detail the toll of unintended pregnancy on women's lives and health status. The goal of this analysis is to provide an accurate metric for assessing the consequences of unintended pregnancy and to stress the fact that behind every statistic is the real life of a woman or girl, wife, mother, daughter, or sister, thereby shedding light on the hidden epidemic of premature death and disability that plays itself out in thousands of communities every minute of every day. The document may be downloaded at <http://www.globalhealth.org/assets/publications/PromisesToKeep.pdf>.

